



# ***The Modern Hospital***

**DECEMBER 1951**

*Can political means gain professional ends? • Dream of  
an operating room supervisor • Punch card accounting for the  
small hospital • Organization of the hospital pharmacy •  
Getting industry into the fund-raising act • Christmas in the hospital*



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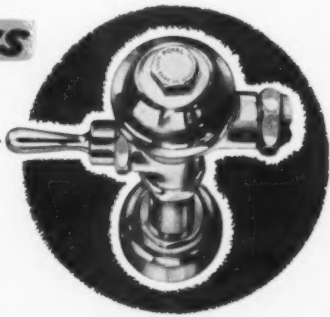
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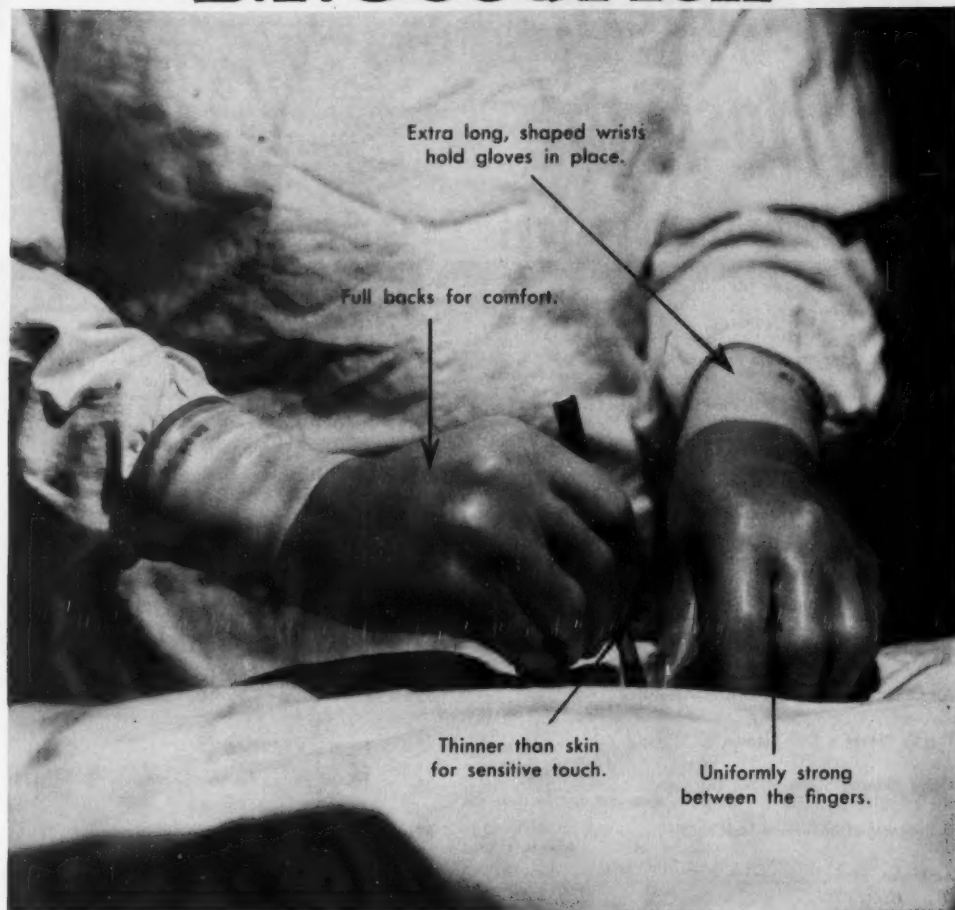
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# The Modern Hospital

DECEMBER 1951

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## AMONG THE AUTHORS

Gladys S. Blizzard, a surgical supervisor who presents her "dream of an ideal operating room" on page 73 of this issue, is now studying for her degree in science at Northwestern University, Chicago. A graduate of the school of nursing at Wesley Memorial Hospital there, Mrs. Blizzard worked in the operating rooms at Wesley following her graduation as head nurse of E.N.T. surgery. Then she took a postgraduate course in operating room technic and management at the University of Chicago; it was during this period of postgraduate study that she wrote about the "ideal operating room" to be presented in this and succeeding issues of *The Modern Hospital*.



Gladys S. Blizzard

Dr. Maxwell S. Frank, a native New Yorker, received his medical degree from the New York University-Bellevue Hospital Medical College. After several years of general practice, he entered the field of hospital administration as a resident under the preceptorship of Dr. J. J. Golub at the Hospital for Joint Diseases of New York. Following this, he was assistant director at New York's Mount Sinai Hospital. In 1945, he was appointed director of New York's Beth Israel Hospital, his present position. Within the last year, the social service department, originally founded at his institution in 1907, was completely reorganized in accord with modern concepts, and the article which appears in this issue, written in collaboration with the hospital's director of social service, offers a glimpse into the vistas opened by the application of modern social service technics in a general hospital.



Dr. Maxwell S. Frank

Freda B. Goldfeld, co-author with Dr. Frank of the article on page 70, is a graduate of the New York School of Social Work, a division of Columbia University. She entered the field of medical social work following several years' experience as a case worker with a family agency, where she saw the impact of illness and handicapping conditions on family unity and well being. Her hospital experience in New York City over a number of years has been as supervisor in the social service department at Mount Sinai Hospital, then as director of the social service departments at Lebanon Hospital and Montefiore Hospital. In the last two positions she was responsible for reorganization of the departments and stimulated development of programs of case work service to patients by a professionally trained, competent staff. In 1947 and 1948, Mrs. Goldfeld worked with the American Joint Distribution Committee as medical social consultant with the medical department at its headquarters in Paris.



Freda B. Goldfeld

Margaret J. Denniston, whose philosophy of nursing is summarized in the article on page 75 of this issue, has been director of nursing and nursing education in a number of hospitals and schools throughout the United States and Canada. She is a graduate of the Montreal Hospital school of nursing and also of the school for graduate nurses at McGill University, Montreal. In addition to her nursing studies, Miss Denniston holds a bachelor's degree in science from the University of Minnesota and an M.A. degree from Teachers College, Columbia University. Now retired from active duty in nursing service and education, Miss Denniston makes her home in Chicago.



Margaret J. Denniston

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# Roving Reporter

## Operation Doesn't Halt Party

The event of the year for employees of the Lake Wales Hospital, Lake Wales, Fla., is the annual nurses' Christmas party. Last year it was held in the men's ward, which is the largest room in the 50 bed hospital and has an adjacent small solarium.

The hospital is a one-story building,

shaped like a T with an elongated head and a short tail, the latter being the private pavilion, with children's and women's wards. At one end of the head is the maternity department, including the delivery rooms; at the other are the Negro and white men's wards and auxiliary departments, such as x-ray, laboratory, emergency and operating

rooms—the latter being across the hall from the white men's ward.

Committees to handle the program, invitations and refreshments were appointed at the regular monthly nursing and administrative conference.

The lone occupant of the men's ward last Christmas was Bob, a lad of 19, who, in his four weeks of being suspended in a pelvic sling, had never been heard to utter a groan. His ever present good humor and ready smile were a tonic to all of us. After receiving permission from his parents, we decided to make him guest of honor.

Bob's excitement was intense. He supervised the decorating and joined in the gaiety and jokes of the decorators, the latter being mostly about how we were going to hide him from the gaping public.

His fracture frame was gaily trimmed with Brazilian pepper, that beautiful holly-like plant which abounds in Florida. The bed was pushed back into one corner and a highly bedecked Christmas tree was placed in another. The bedside stand was turned with its front to the wall to make a table for the record player. Many chairs and small tables were brought in the room and, with its windows ornamented with Christmas greens and new draperies, it no longer looked like a ward. A big red bell hung from the chandelier, along with a sprig of mistletoe.

We decided to invite members of the medical staff and the executive committee of the board of directors and their wives. Each employee was allowed to bring a guest, and any employees having small children were allowed to bring them. Since the men's ward is adjacent to the ambulance entrance, admittance of the small guests did not conflict with regulations regarding child visitors.

Our well-known Lillie Mae, whose culinary results are renowned in the community, with the help of her assistants, set up a beautiful buffet supper in the adjoining solarium. This was topped off with a huge Italian pottery bowl of ambrosia, the dessert which is virtually a Christmas ritual in every southern home. The wife of one of our doctors added to this a holly decorated Christmas cake and huge salvers of canapés. Housemaids and kitchen maids put in a full 16 hour day; they asked only that one of the nurses, who keeps up with the latest in dance steps, give them a special audition with her husband.

As the final touches were being added to the buffet table, in walked a prospec-



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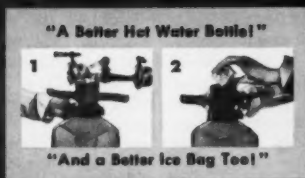
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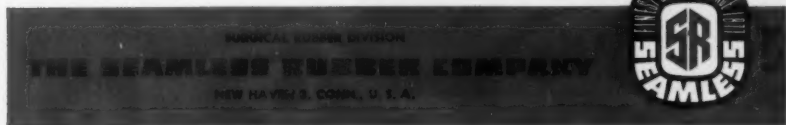
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tive mother, who immediately was rushed to the delivery room. The administrator, after hurriedly greeting several guests, the first arrivals, hurried back into the office to answer a telephone call from the chief of staff, who said, "I hate to break into your party, but will you please have the operating room set up immediately and please call the anesthetist and operating room nurse. I have an emergency appendix patient on the way in."

A few minutes later both the anesthetist and the operating room nurse arrived all dressed for the party and

had quickly to change into operating apparel. When the ambulance drove up with the patient, everything was in readiness and the arriving guests made a lane for the stretcher as it came up the corridor.

In the meantime, two school teachers had come bearing a portable organ and led the singing of Christmas carols; these did not disturb the operating team.

To cap the climax, in the midst of both operation and Christmas party, an accident case arrived. More nurses at the party were called into action, along with the x-ray technician and one of

the doctors, and a fractured leg was set and the patient put to bed.

Nothing interfered with that party! Ambulatory patients and patients' visitors joined the gathering. Santa was there in full regalia and with a full pack of presents for everyone. Neither guests nor hostesses seemed dismayed or inhibited by the situations that kept occurring. The whole affair went off with a smoothness that is still being discussed. Those girls who had been called back on duty to handle the emergencies later rejoined the party; nurses on regular evening duty took part as their duties permitted, and bed patients were settled for the night in regular routine.

The administrator is very proud of a group that could handle so difficult a situation, both from the professional and social angles, with *savoir faire*. She knows now that any emergency will be equally well met by the hospital employees.—ISABELLA N. WILLIAMS, administrator, Lake Wales Hospital, Lake Wales, Fla.

## Christmas Minus Trees

About the middle of November, a rash of plans for Christmas decorating breaks out among members of the Hartford Hospital family, Hartford, Conn. New themes and new motifs are dreamed up.

Artists' supplies are requisitioned from the purchasing department, where warning is given that all materials are to be fireproofed at the paint shop and inspected by the proper authority. At the end of the month entry blanks appear in *Rx-tra*, the hospital's weekly news sheet. Thus the hospital's annual Christmas decorating contest gets under way.

It all started back in 1946, following two disastrous fires in the city of Hartford within 18 months. The first of these fires was that of the Ringling Brothers' Circus of July 1944. The second was the Christmas Eve fire of December 1945 in the Niles Street Hospital, a private institution, in which both patients and firemen were among the casualties.

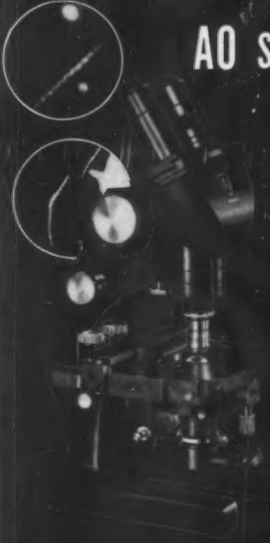
The cause of the latter fire was, ironically enough, a string of faulty Christmas tree lights!

After these two tragedies, the city of Hartford became fire-conscious in a big way. New regulations for protection and prevention were passed. At Hartford Hospital a former city fire captain was appointed the first full-time fire

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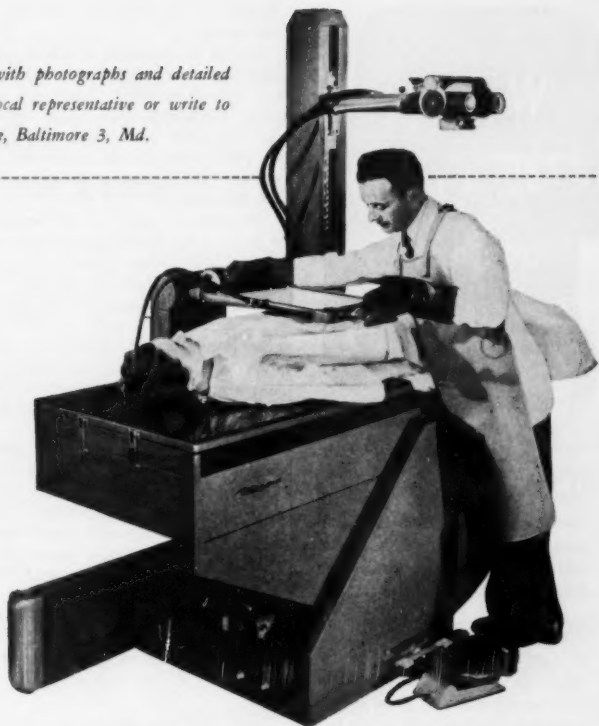
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marshal in any voluntary hospital in the country.

One of the outcomes of this appointment was a set of rigid rules regarding Christmas decorations. Thus it was that, when December 1947 rolled around, not only were there orders forbidding the use of materials not fireproofed, but the use of Christmas trees and greens was forbidden.

The defeatist spirit did not last long. A nurse in the pediatric department got hold of some poster paints and with a cotton swab produced a gay little tree, bright with trimmings, on the glass of a cubicle. With a paste made from a cleansing agent, she dabbed away until there was a realistic snowstorm. A volunteer on the floor caught the urge and painted a jolly fat Santa with two of his reindeer.

Enthusiasm for painting soon spread to other floors and departments. Every cubicle, every window and door panel were made bright with holiday scenes.

No one came around to shake a head with disapproval because poster paints can't catch on fire and are readily removed from a smooth hard surface.

The general excellence and originality of the work were surprising. It was decided to honor the Christmas effort with prizes for the most artistic decorations.

Since 1947 the decorating contest has been held annually. Four years later the entries have grown to be so numerous that they are being divided into two groups: those on patient floors and those in other hospital departments. There are now virtually no restrictions on material as long as it is properly fireproofed.

Some of these amateur artists climb to ambitious heights. Last year every available surface of one pediatric wing was given over to depicting "A Visit from St. Nicholas." An engineering department crew yearly uses the apparatus room as the setting for a still-



life tableau of the nativity or some other biblical theme.

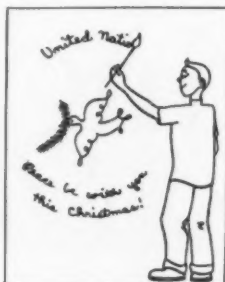
The medical records department presented a Santa Claus workshop, replete with shelves of toys and a life sized Santa at his desk. A Chinese resident doctor did a design for the emergency entrance that not only featured the Christian festival of Christmas but celebrated the unifying possibilities of the U.N.

A little humor sometimes is to be found, as in the miniature painting of an angel on a bedpan hopper room door. Under the painting was the glad greeting, "Hopper New Year!"

From the street at night, when the lights from within shine through the paintings, the main façade of the 13 story building looks like a huge stained glass window.

The women's auxiliary took over the management of the contest in 1948 and continues to sponsor it. This organization arranges for the judges, usually representatives of local garden clubs, and awards first, second, third, and honorable mention prizes in each group. These consist of gift certificates redeemable at the auxiliary store. In one altruistic instance, a winner placed an order for records for the record player in the pediatric department.

The Christmas spirit is manifested at Hartford Hospital in other ways. The







# What to look for

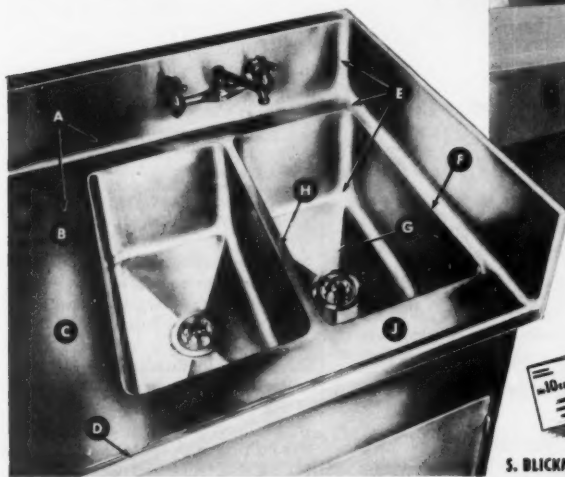
## in HOSPITAL CABINET CONSTRUCTION

### Note these "Blickman-Built" features:

- A**—The one-piece top and splashbacks are seamlessly welded and coved where joined. All corners and intersections are fully rounded to eliminate dirt pockets.
- B**—The crevice-free seamless top is a smooth, continuous surface with all corners welded and joints eliminated.
- C**—The top is sound-deadened by a sub-plate of No. 14 gauge (.078") furniture steel.
- D**—The raised edges prevent spilling of liquids. The inverted "V"-edge front is integral with top and end.
- E**—All vertical and horizontal corners of sink are fully rounded and intersections of corners are spherically coved.
- F**—Sinks are seamlessly welded to top so that there are no dirt-catching crevices.
- G**—The bottom of sink drains completely, because it is scored and pitched to outlet.
- H**—The sink partition is double-walled and made of one sheet of metal, rounded at top and integrally welded.
- J**—Stainless steel of heavy gauge (never lighter than No. 14, .078") is polished to No. 4 mill finish, rather than having just a "grind" finish.

### Stainless steel sinks and work tops should be of all-welded, round-corner construction

• When your cabinets require sinks or work tops, be sure they are made of heavy-gauge stainless steel in all-welded, seamless construction. This assures cleanliness, strength and durability and practically eliminates maintenance and replacement costs. Rounded corners and coved intersections simplify the task of cleaning. The stainless steel surfaces are permanently bright and attractive. See the column at the left for other important features. When these units are built to "Blickman" specifications, you are assured of hospital cabinets and case work that will give years of efficient service.

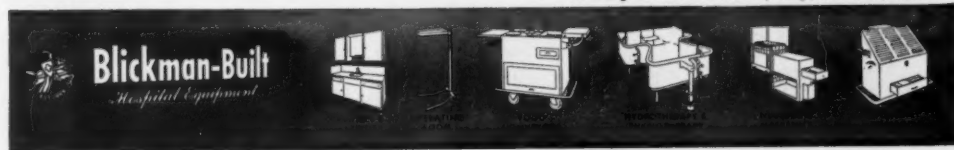


Blickman-Built stainless steel cabinets and work counter at St. Peters Hospital, Albany, N. Y.

**Blickman-Built cabinets and case work** are made of stainless steel as well as enameled steel. Recessed and free-standing units built to specifications. Layout and engineering service.

**SEND FOR BULLETIN No. 10 CBC** which describes and illustrates all types of Blickman-Built cabinets and case work for every hospital department . . . Send also for the May issue of "Trends," carrying a feature story about Blickman-Built cabinets.

**S. BLICKMAN, INC. • 1512 Gregory Ave. • Weehawken, N. J.**  
New Eng. Branch: 845 Park Sq. Bldg., Boston 16, Mass.



women's auxiliary decorates the main lobby, which, because of its size, calls for something striking. Also the auxiliary sponsors a toy tea, held in the board of directors' room, to which each member brings a toy or a check. This results in so many handsomely wrapped and properly tagged gifts that there is a stock of toys on hand the greater part of the year, to draw on as needed for small patients.

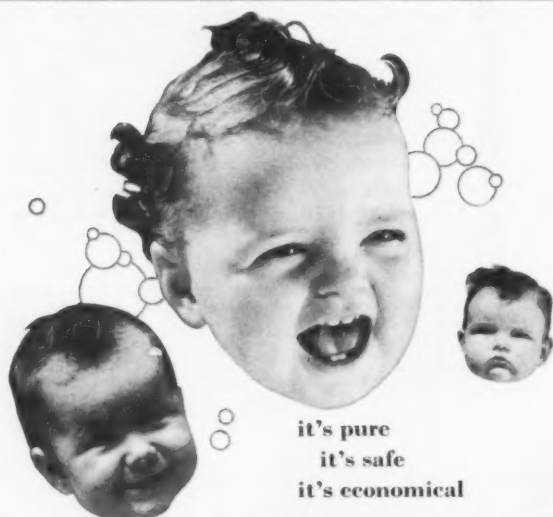
The dietary department, of course, makes memorable contributions to the holiday observance with special menus and menu cards, tray covers and fancy

confections. Last year it produced, in addition, a gingerbread house, complete in every detail. This received its most ecstatic "Oh's" and "Ah's" from the children but also was much admired by the visiting public when it was exhibited in the lobby.

The community plays its part in the hospital Christmas, too. The public relations department is busy weeks ahead scheduling those who wish to sing carols, such as church choirs and school glee clubs, and the girl scout troops, Junior Red Cross, Sunday school classes and others send favors.

The climax for the very young is reached on Christmas morning when Santa Claus pays a visit with his bag of toys. Underneath the beard there lurks, in accord with time-honored custom, an intern.

Christmas in a hospital without a tree? It isn't as grim as one might at first expect. Hartford Hospital and probably many similar institutions have learned that the true spirit of the season can't be kept down by a few fire rules and regulations!—LYDIA HEWES, *director of public relations, Hartford Hospital, Hartford, Conn.*



## best for bathing babies

**BABY-SAN** Liquid Castile Soap has these important advantages over ordinary soaps in your nursery. 1. It gives baby a better chance for skin health. It's compounded especially for babies, quick cleansing but gentle. 2. It lubricates and keeps the skin soft and free from chafing. 3. Nurses like Baby-San because it is easy to use in the handy dispenser. 4. It's economical . . . a few drops are enough for the bath, none need be wasted. Ask for sample.



HUNTINGTON LABORATORIES, INC.  
Huntington, Indiana • Toronto, Canada

**Baby San.**  
AMERICA'S FAVORITE BABY SOAP

### Poor Coffee Isn't Necessary

If 71 per cent of the patients liked the coffee served them, not every hospital would bother about the other 29 per cent. But Bishop Clarkson Hospital in Omaha thrives on criticism; it asks for it, it gets it, and it does something to improve the situation.

Having been told that 29 per cent of the 422 Clarkson patients who filled out a questionnaire inviting criticism found fault with the coffee, Mrs. Helen Shuput, chief dietitian, looked about for a coffee taster. Administrator Hal F. Perrin was the man of her choice, and he went from floor kitchen to floor kitchen sampling the coffee. He found that the same coffee did not taste the same on all floors.

The dietitian then interviewed the patients individually. That yielded nothing new in results. Her next step was to call in a coffee distributor with 56 years of experience behind him. From that time on, changes began to follow each other in rapid succession.

Old two-switch coffee makers were replaced by new coffee "stoves" with controlled temperatures. "Cup" measurement, the dietetic staff observed, was not identical. Coffee is now ordered in 2½ ounce packages, lowering the margin of error in measurements. The old metal coffee pots had no indicators; these were replaced by glass coffee makers with a water line indicator.

The next step was to retrain the floor girls. Typewritten instructions for correct coffee preparation, as recommended by the Pan American Coffee Bureau, were posted in each floor kitchen. This was followed by demonstrations given by the dietitians.

"I might add," Mrs. Shuput declares, "that the dietitians learned to brew a mean pot of coffee. An infinite amount of care and attention is now going into our coffee preparation."

# Save Labor in Your Laundry

with TROY  
ELECTROMATIC "Slide-Out" WASHERS



Unloading clothes from 350 lb. capacity Electromatic "Slide-Out." Photo courtesy of American Institute of Laundering, Joliet.

## AUTOMATIC WASHING SAVES LABOR

All you do is set Electromatic control dial, add supplies, and the rest of each washing operation is automatic. When cycle is completed, turn control dial to "spot" and cylinder automatically lines up with shell door for unloading.

## EASY UNLOADING SAVES LABOR

No more lifting heavy wet work from bottom of the washer! A scoop of the arm SLIDES load from washer shelf into truck tub, easily and quickly.

## LESS MAINTENANCE SAVES LABOR

Troy "Slide-Out" Washers have no complicated gears, pistons or other expensive devices to keep in repair. Corrosion-proof, heavy duty stainless steel construction is your assurance of long, trouble-free service.

### SIZES

42 x 36"	.....	150 lbs. Capacity
42 x 54"	.....	225 lbs. Capacity
42 x 84"	.....	350 lbs. Capacity
42 x 96"	.....	400 lbs. Capacity

Also available with manual controls. Ask your Troy representative or write the Troy factory for illustrated catalog.

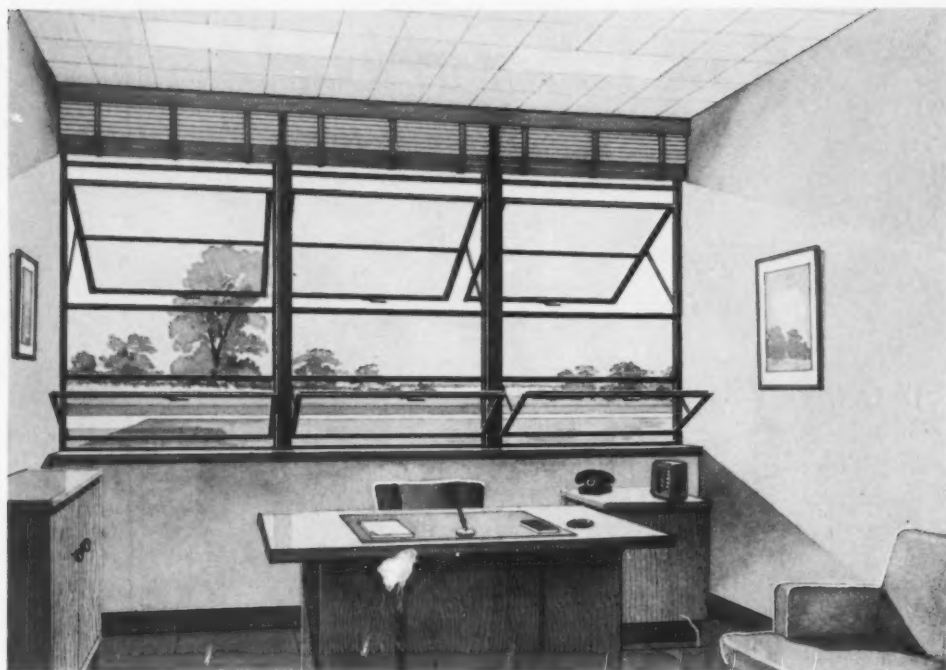


\*"Slide-Out" is a trade-marked name. Only Troy builds Slide-Out Washers.

# TROY

## LAUNDRY MACHINERY

Division of American Machine and Metals, Inc.  
EAST MOLINE, ILLINOIS  
World's Oldest Builders of Power Laundry Equipment (Since 1868)



## Help for Major Operations . . .

Efficient, pleasant surroundings ease the tough job of keeping hospital costs in hand. Take this airy superintendent's office for instance, the big, narrow framed Lupton Metal Windows increase glass area, make the room seem larger and more cheerful. Easy to operate, they provide comfortable, draft-free ventilation, instantly controllable for any weather.

Step by step precision manufacturing assures windows that will not warp, swell, shrink or rattle—drastically cut maintenance costs. Deep section members add rigidity for maximum strength.

Available in Steel and Aluminum, Lupton Metal Windows are designed for long life with low maintenance costs. For complete details, get in touch with your local Lupton Representative, or write for General Catalog.

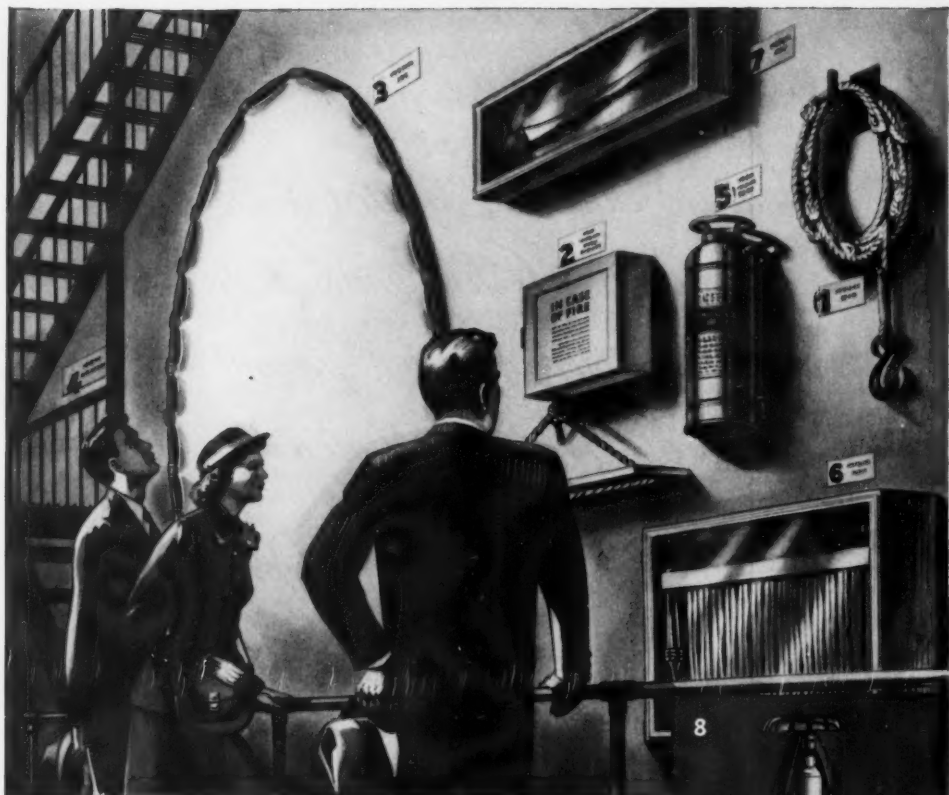
**MICHAEL FLYNN MANUFACTURING COMPANY**

700 East Godfrey Avenue, Philadelphia 24, Penna.

*Member of the Metal Window Institute & Aluminum Window Mfrs. Assn.*

# LUPTON

## METAL WINDOWS



1) Knotted Rope—for hand-over-hand descent from windows. 2) Self-lowering Bo'sun's Chair. 3) Fireman's Net. 4) Fire Escape. 5) Hand Extinguisher. 6) Hallway Hose. 7) Axe. 8) Grinnell Automatic Sprinkler.

## Which would you trust to save YOUR life?

If you were to look over all of the devices that man has contrived to protect himself against fire, you would find a notable weakness in all except one. Until the advent of automatic sprinklers, all had the unreliability of the human element. The fire hose in the hands of a panic-stricken novice. The rope descent for the aged and the weak. The net for those robbed of courage to jump. No, if your own life

were concerned, you wouldn't trust these.

How infinitely better to have the fire automatically stopped . . . *before* the damage is done! With Grinnell Automatic Sprinkler Systems fire can be checked at its source, wherever and whenever it may strike, night or day, with automatic certainty. And seventy years of experience prove Grinnell's reliability.

**SEE THAT GRINNELL SPRINKLER HEADS ARE ON GUARD.** In hospitals, there is a moral obligation upon management for the utmost in protection of life and property. So, for your own sake, be sure the lives for which you are responsible are protected with Grinnell automatic sprinkler heads — your assurance of positive fire protection.

**GRINNELL**  
FIRE PROTECTION SYSTEMS



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*You are cordially invited to be our  
guest on Christmas Day  
at a one-hour television presentation  
of Walt Disney's*  
**"CHRISTMAS SHOW"**



his delightful Disney production,  
created especially for Christmas,  
is dedicated to the doctors, interns, nurses,  
and hospital workers of America—in appreciation of their  
untiring efforts in behalf of all humanity.

*A Christmas program appealing to all ages. See your  
newspaper for the time and the local television station.*

**Johnson & Johnson**



For this baby  
only the best will do



and he HAS the best . . . a Hollister Inscribed Birth Certificate

See for yourself how pleased each new mother is when you give her your hospital's own Hollister Inscribed Birth Certificate.

For every mother knows her baby is the most wonderful baby in the world, and should have the very best of everything. This Birth Certificate is an especially appreciated gift — it tells her that you and your hospital are personally interested in her baby. She will treasure this certificate always — it will remind her, for many years to come, of your

thoughtfulness and of the fine care she and her baby had at your hospital.

Remember — for the babies born in your hospital only the best will do. You'll want Hollister Inscribed Birth Certificates designed especially for your hospital, including your hospital's name, and picture or drawing, if you wish.

Send TODAY for your free copy of the 1951 Birth Certificate portfolio and select the style you want for your hospital.

**Franklin C. Hollister Company** GOODWILL BUILDERS FOR HOSPITALS

843 N. ORLEANS ST., CHICAGO 10, ILLINOIS

Please send me, without charge, my copy of the 1951 Birth Certificate portfolio, containing actual samples.

NAME \_\_\_\_\_

HOSPITAL \_\_\_\_\_

ADDRESS \_\_\_\_\_

# Schools for Prepared Parents

*Does YOUR hospital have classes for prospective mothers?*

In many hospitals prospective mothers, and often fathers, too, attend regular weekly classes to learn more about preparing for parenthood . . . proper prenatal care for mother and baby . . . what to expect and plan for after their babies are born . . . the physical and emotional needs of new babies.

Through this valuable help given them by their hospitals, prospective mothers and fathers acquire self-confidence, a feeling of security . . . and they are especially pleased and proud when they receive their special Certificates for Prepared Parents.

## **Special Certificates for YOUR Hospital**

Certificates for Prepared Parents will be designed for your hospital — including your hospital's name and picture, if you wish.

*For free samples — mail the coupon today.*



*Hollister Hainloom Quality*

FRANKLIN C. HOLLISTER CO. — 843 N. ORLEANS ST., CHICAGO 10

Please send me by return mail actual sample of special Certificate for Prepared Parents.

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HOSPITAL \_\_\_\_\_

ADDRESS \_\_\_\_\_

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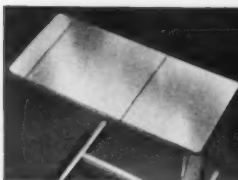
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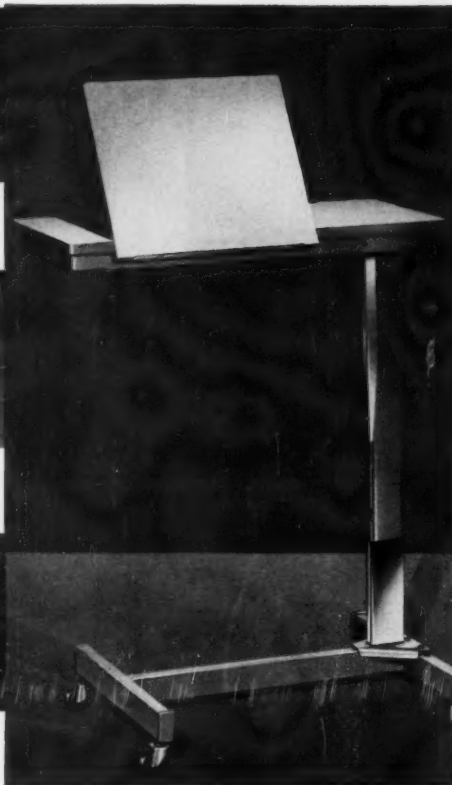
Ever see such a big top on an overbed table? 14 1/4 x 31 1/4 inches! Its 5-ply laminated base is covered with tan and grey Zalmite. Resists damage by heat, cold and spilled liquids.



Note the balanced spread of this sturdy base. And the extra bracing clamp where base meets pedestal upright. Note, too, that base is equipped with casters for easy moving; glides for stability.



Double hinged center-section permits full use of table from either side of the bed. Patient has advantage of using full section as book or magazine rest, and of a larger mirror when used as a vanity.



The full width, movable center section will hold a large magazine or a folded newspaper. Note the flat surface area at right of rack, ample for articles in use when center section is raised.



This big stainless steel tray gives the patient room for personal articles, writing materials, etc. This tray is also available finished in porcelain enamel (F-884). Note, the large size of the mirror.



To raise or lower, patient simply presses on hand grip, and the counterbalanced table top adjusts to one of 15 positions, graduated 1 inch apart. Can be lowered to 29 1/4"—for use by patient seated in chair.



## Only Simmons Overbed Table has all these features!

Illustrated here are the 6 outstanding features of Simmons new single pedestal overbed table—F-885. *Compare it with any other table.* You'll soon see why we say it offers more value in construction features, sturdiness, utility and quality.

See this new, improved Simmons Overbed Table at your hospital supply dealer's showrooms, or at any of the Simmons display rooms whose addresses are listed below. Or, write today for complete details, including quantity prices.

**SIMMONS COMPANY**  
HOSPITAL DIVISION

### Display rooms:

Chicago 54	San Francisco 11	New York 16	Atlanta 1
Merchandise Mart	295 Bay Street	One Park Avenue	353 Jones Avenue N. W.

# Logically

... You'll want to  
eliminate outmoded technics and  
equipment with

## POUR-O-VAC SEALS

the modern, reusable hermetic closure  
for sealing, storing, handling and con-  
serving surgical fluids.

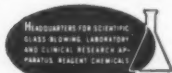
### THESE FACTS ARE CONVINCING...

Pour-o-vac Seals eliminate the possibility of sterile water contamination caused by intake of bacteria-laden dust . . . avoids contamination by unfiltered air.

They serve a secondary function of providing a dustproof seal for remaining fluid when only the partial contents of a container are used. Of importance, they are interchangeable with all Fenwal 3000, 2000, 1000 and 500 ml. containers.

In permitting contents to be stored for long periods under vacuum . . . periodic testing for sterility without breaking the hermetic seal . . . pouring of contents from a non-drip sterile lip, Pour-o-vac seals eliminate the wasteful, time-consuming and questionably scientific method of sealing with gauze, cotton, paper, string and tape.

**ALSO INVESTIGATE**—Fenwal Automatic Washing Units, capable of accommodating and thoroughly cleansing 4 containers in 30 seconds.



ORDER TODAY or write immediately for  
further information



**MACALASTER BICKNELL COMPANY**

243 Broadway

Cambridge, Massachusetts





# ECONOMY

IN THE COSTLY CARE OF CHRONIC OSTEOMYELITIS

## *Tryptar* \*

In chronic osteomyelitis, therapy that hastens recovery is an economy reflected in many ways. Tryptar is dramatic in reducing recovery time from years to months or even weeks.

Tryptar, selectively, causes dissolution of necrotic tissue and removes debris without injury to normal tissue. With topical administration, Tryptar is non-toxic and completely non-antigenic.

Tryptar in the treatment of osteomyelitis may be applied in the form of dry powder, in wet dressings, in gelatin capsules or by irrigation, depending upon the location of the lesion.

Tryptar is supplied as a two vial preparation: one 30 cc. vial contains 250,000 Armour Units (250 mg. of Tryptic Activity) of highly purified crystalline trypsin; the companion 30 cc. vial contains 25 cc. of Tryptar Diluent (Sorensen's Phosphate Buffer Solution) pH 7.1. Plus plastic adapter for use with powder blower.

\*THE ARMOUR LABORATORIES BRAND OF PURIFIED CRYSTALLINE TRYPSIN

### OTHER INDICATIONS

Amputation Stumps  
Burns  
Carcinomatous Ulcers  
Chest Surgery  
Decubitus Ulcers  
Diabetic Gangrene  
Empyema  
Infected Compounded  
Fractures  
Soft Tissue Abscesses,  
Sinuses, Fistulae  
Subcutaneous Hematoma  
Varicose Ulcers



**THE ARMOUR LABORATORIES • CHICAGO 11, ILLINOIS**

*world-wide dependability*

PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

Vol. 77, No. 6, December 1951

19

Even greater sanitation  
Even longer life.....

that's the  
"inside story"  
of the *NEW*



## POLAR WARE Stainless Steel BED PAN

BED PANS all serve the same purpose . . . but that ends the similarity you'll find between the new Polar Ware pan and others . . . for this gleaming, highly polished stainless steel pan is fully seamless in construction. The most advanced welding process makes this better bed pan in one solid piece, free from any weld lines or fusion marks from which unsanitary cracks or check marks radiate. The inside has a satin-smooth surface everywhere. There is no area that can harbor bacteria, no concealed section that ordinary aseptic methods will not make sterile.

To this unduplicated method of construction, add the sturdy gauge stainless steel that is always identified with everything Polar Ware makes. This means

a bed pan that has years of extra life in the service it delivers, one that will still be in every day use long after thinner gauge pans have been discarded and forgotten. It's good to know, too, that this improved Polar Ware pan comes your way without any premium in price, provides you with the best in bed pans at a cost that is competitive with products that fail to offer the same degree of service.

For this reason, and many more, you'll find Polar Ware carried by leading supply houses from coast to coast. Ask the salesman who calls on you, or write

**Polar Ware Co.**

4300 LAKE SHORE ROAD  
SHEBOYGAN, WISCONSIN



# AIRKEM KILLS ODORS



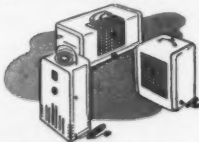
## ... from Pathological Labs



Airkem Mist dispenser for sudden or "emergency" odors.



Airkem Wick Bottles service approximately 100 sq. ft. Tamper-proof wall cabinets available for permanent locations.



Airkem Oumefan H-2 treats approximately 300 sq. ft. . . . Airkem Oumefan V-4—approximately 600 sq. ft. . . . Airkem Oumefan H-8—approximately 1,000 sq. ft.



Airkem Wifloat may be attached to "packaged" air conditioners to service intermediate spaces. Oumetrol, A.E. for large central systems.

Unpleasant odors from pathological laboratories and the eight other odor-breeding areas listed below can do your hospital a great deal of unnecessary harm . . . because these odors often upset and irritate your visitors, patients and staff.

While air conditioning or ventilating systems may *slowly* dispose of unwanted odors, Airkem—the full-time odor counteractant—kills them as *soon* as they happen. And Airkem conveys a pleasant air-freshened effect.

Realizing this, more than 1,000 leading hospitals from coast to coast use Airkem for continuous odor counteraction in all nine trouble areas.

Airkem combines chlorophyll with more than 125 compounds found in nature to produce an odor counteractant of unusual efficiency. And Airkem is compounded under strict laboratory control to insure utmost uniformity.

For low-cost, around-the-clock odor control, ask your Airkem Supplier about Airkem's Monthly Service Plan. An Airkem service man regularly checks and replenishes your supply of Airkem . . . without interruption to your hospital schedule. Call your Airkem Supplier today or write to Airkem, Inc., 241 East 44th Street, New York 17, N. Y.

### Odor-protect in all 9 trouble areas:

- |                      |                         |                    |
|----------------------|-------------------------|--------------------|
| 1 PATHOLOGICAL LABS  | 4 FRESHLY PRINTED AREAS | 7 KITCHENS         |
| 2 AUTOPSY ROOMS      | 5 LAVATORIES            | 8 ODOROUS DISEASES |
| 3 LAUNDRY AND CHUTES | 6 UTILITY ROOMS         | 9 OPERATING ROOMS  |

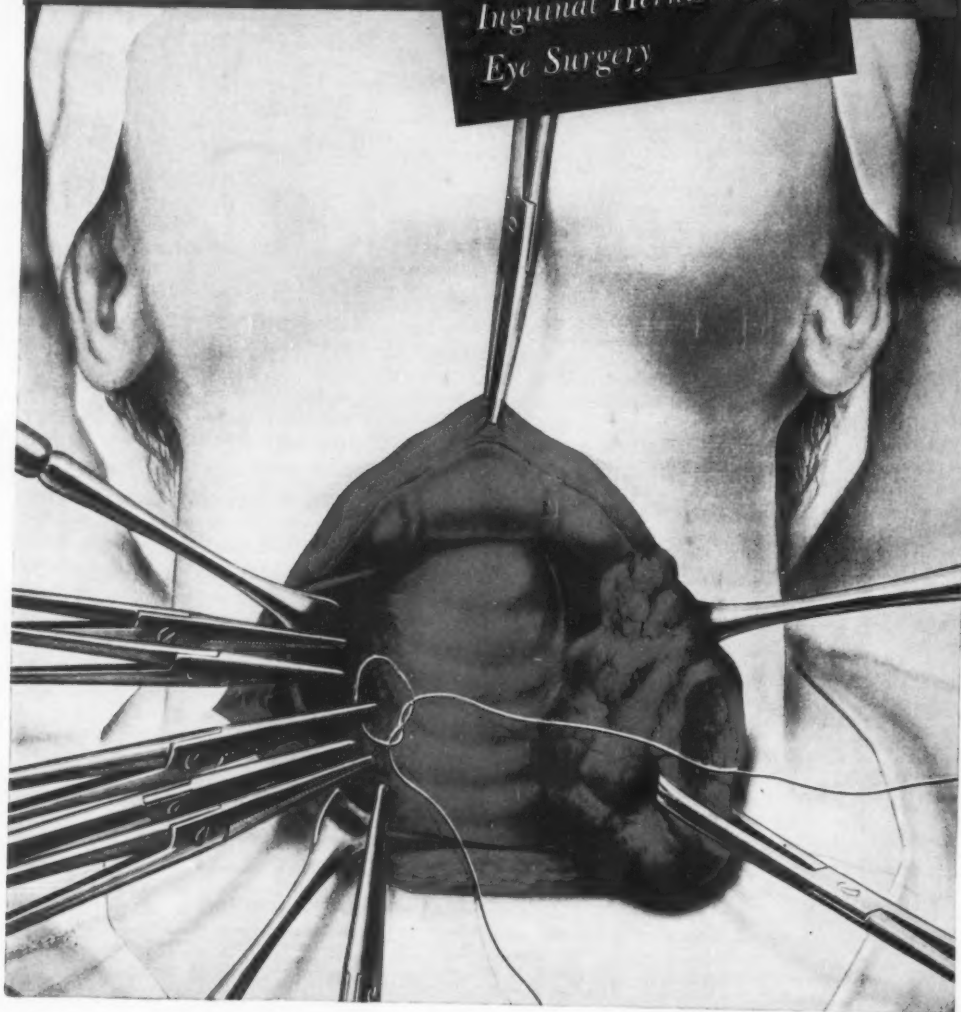


THE ODOR COUNTERACTANT FOR PROFESSIONAL USE



*Whenever "silk technic" is the  
surgeon's choice...*

Thyroidectomy  
Gastric Resection  
Inguinal Herniorrhaphy  
Eye Surgery

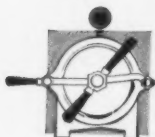


*New improved* **ANACAP<sup>®</sup>**  
**SURGICAL SILK**

**5** *ways better than ever before*



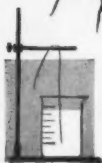
- 1. Greater tensile strength:** One of the strongest silks ever created—smaller diameter sizes can be used everywhere to minimize trauma and foreign body reaction.



- 2. Withstands repeated sterilization:** New Anacap Silk can be boiled or autoclaved *six separate times* without appreciable change in either strength or texture. In laboratory tests almost the full original strength is maintained even after 23½ hours of boiling.



- 3. Easier to handle:** Firmer, not limp, Anacap Silk speeds operative technic. Braided by a new method that minimizes "splintering" and "whiskering" it passes readily through tissues. The ease of handling Anacap makes it a "new experience" in silk suturing.



- 4. Absolute non-capillarity:** Having no wick-like action, new Anacap Silk is resistant to body fluids and will not spread an early localized infection if it occurs.

- 5. Doubly economical:** Low in original purchase price, new Anacap Silk is also low in individual suture cost because of its long sterilization life.

*In sizes 6-0 to 5 on spools of 25 and 100 yards; sterile in tubes with and without D & G Atraumatic<sup>®</sup> needles attached.*

**DAVIS & GECK, INC.**

57 Willoughby Street,



Brooklyn 1, N. Y.

Quantity Recipe Service

**BUSIEST**

Blue-and-white metal G.F. Recipe File Box — large enough for hundreds of cards — costs only 400 General Foods premium coupon points!



**JELL-O**

**Mincemeat Pie**

YIELD: 4 1/2 quarts filling  
6 1/2-inch pies—3 cups filling per pie

INGREDIENTS	WEIGHT	APPROX. MEASURES	AMT. WHEN PREPARED
Cherry Jell-O	2 1/2 pounds	2 1/2 cups	2 1/2 cups
hot water (160°-165° F.)	4 pounds	2 1/2 quarts	2 1/2 quarts
mincemeat	6 ounces	1 1/2 cups	1 1/2 cups
chopped nut meats	6	6	6

baked 9-inch pie shells

1. Dissolve Jell-O in hot water. Chill until slightly thickened.
2. Fold mincemeat and nuts into slightly thickened Jell-O.
3. Turn mixture into baked pie shells, allowing 3 cups filling per pie with sweetened whipped cream, if desired.

**Cranberry and Orange Relish**

YIELD: 4 quarts

INGREDIENTS	WEIGHT	APPROX. MEASURES	AMT. WHEN PREPARED
Cranberry Jell-O	2 1/2 pounds	2 1/2 cups	2 1/2 cups
hot water (160°-165° F.)	4 pounds	2 1/2 quarts	2 1/2 quarts
orange juice	2 1/2 quarts	2 1/2 quarts	2 1/2 quarts
orange segments	2 1/2 quarts	2 1/2 quarts	2 1/2 quarts

1. Dissolve Jell-O in hot water. Chill until slightly thickened.
2. Add orange juice and segments. Chill until slightly thickened.
3. Turn mixture into baked pie shells, allowing 3 cups filling per pie with sweetened whipped cream, if desired.

**Tomato Aspic and Cottage Cheese Loaf**

YIELD: 4 quarts

INGREDIENTS	WEIGHT	APPROX. MEASURES	AMT. WHEN PREPARED
Tomato Aspic	2 1/2 pounds	2 1/2 cups	2 1/2 cups
Cottage Cheese	4 pounds	2 1/2 quarts	2 1/2 quarts
Onion	2 1/2 quarts	2 1/2 quarts	2 1/2 quarts
Pepper	2 1/2 quarts	2 1/2 quarts	2 1/2 quarts



PEOPLE WHO TALK ABOUT GOOD FOOD...  
**TALK ABOUT GENERAL FOODS!**

# SUGGESTION BOX *in* AMERICA!

## HERE'S WHY TENS OF THOUSANDS USE GENERAL FOODS QUANTITY RECIPE SERVICE!

**For menu variety at low food cost,  
you, too, will want to enjoy these 5 big benefits:**

- 1** You get hundreds of recipes for low-cost entrees, soups, salads, desserts and quickbreads—including timely holiday features like those illustrated.
- 2** You receive recipes planned specifically for your type and volume of operation. New recipes (designed for easy indexing) are mailed frequently.
- 3** Your recipe cards specify ingredients, proportions, weights and measures, cooking and serving directions, accurate yields, portion sizes and other data.
- 4** Your recipe cards give careful consideration to seasonal foods, shortages, ease of preparation and other ingredient factors.
- 5** Your recipes are carefully planned and standardized in a test kitchen devoted *exclusively* to quantity food service.

### **They'll make TALK work for you!**


These famous Quantity Recipes are typical of General Foods service in the public feeding field. They help assure *uniform quality* that customers look for and welcome—the same kind of *uniform quality* you find in all the fine General Foods Institution Products folks have used in their own homes for years. For such famous brands as Maxwell House Coffee, Jell-O, Post's Cereals and many, many others, contact your G.F. man or distributor. He always has news about good foods that *make talk work for you!*

### *Easy to get!*

For this free Quantity Recipe service, ask your General Foods man or distributor, or write: Institution Food Service, General Foods Corporation, 250 Park Ave., New York 17, N. Y.

Products of General Foods



A black and white photograph of three surgeons in an operating room. They are wearing white scrubs, surgical masks, and caps. The surgeon on the left is looking down at something in their hands. The other two are looking towards the center. The background is dark and out of focus.

CLEANLINESS, OF COURSE...

BUT WHAT ABOUT *Comfort?*

**ANGELICA Scrub Garments Are Sterile, Absorbent  
... And COMFORTABLE!**

Yes, comfort, too, is vital to the success of an operation... surgeons, assistants and nurses must be able to move freely and in complete comfort at all times. Angelica scrub suits and gowns provide that necessary comfort in many ways...

- roomy sleeves and full cut armholes for complete freedom of movement
- full cut trouser legs and roomy crotches to eliminate binding
- adjustable waistlines in gowns for comfortable fitting
- non-transparent materials that fully absorb perspiration

The newest development in scrub suits is Angelica's scrub "Nittshirt"... made of soft cotton for higher absorbency and constructed with a four inch underarm sleeve for greater freedom of movement.

You'll save money, too, with Angelica hospital apparel... it's thoroughly "task-tested" to assure maximum durability and economy. All seams are completely finished and reinforced at every point of strain to provide the utmost in longer wear and better service.

So, be sure you provide your staff the best in comfort... at less cost... Order Angelica hospital apparel today.

*Angelica Uniform Co.*

1427 Olive, St. Louis 3  
1101 S. Main, Los Angeles 15

177 N. Michigan, Chicago 1  
427 St. Francois Xavier St., Montreal

107 W 48th, New York 19

CONSTANT RESEARCH MAKES ANGELICA FIRST IN HOSPITAL APPAREL DEVELOPMENT





*Bedside Pitcher Set and Hospital Jars*

## **HANDSOME, HANDY AND ECONOMICAL**

The Glasco Bedside Pitcher Set and Hospital Jars make handsome, convenient, sanitary and economical additions to your hospital equipment.

The Bedside Set comprises a sturdy, one-quart pitcher with a specially designed tumbler. Both are made of crystal clear, high-quality glass such as is

used in many types of Glasco fine surgical glassware. Pitcher and glass have broad bases to prevent tipping. Inverted glass acts as cover for pitcher—assures clean water for patient—saves space on trays and tables.

Hospital Jars with overlapping glass, or metal covers, are available in these

sizes: 3" x 3", 4" x 4", 5" x 5", 6" x 6"—a Jar for every need you have. Each is made of carefully annealed glass and is dustproof.

The Bedside Set and the Jars are very attractively priced. Ask your hospital supply salesman, or write us for complete information and prices.

# **GLASCO PRODUCTS CO.**

111 NORTH CANAL STREET, CHICAGO 6, ILLINOIS

*alumiline*

... equipment for the modern nursery



**Alumiline Bassinets Provide Twentieth Century Care for Twentieth Century Babies**

Nowhere is the need for modern functional design more forcefully indicated than in the development of hospital equipment. Such equipment must be primarily built around the idea of getting a specific job done in the most efficient and economical manner possible. For many years the A. S. Aloe Company has stood far out front in the manufacture of hospital equipment designed to speed up the day's work and reduce operating costs. In developing Alumiline furniture for the modern nursery, our designers drew upon a thorough knowledge of both general hospital requirements and local or individual preferences. Wide acceptance of our Ravenswood Bassinet (above) and the Magee Combination Bassinet and Dressing Stand (lower left) is proof of the superior design and workmanship of Alumiline nursery equipment. The Magee Bassinet and Stand has attracted particularly favorable attention because authorities generally agree that it provides sufficient protection to meet the requirements of good individual care, thus eliminating the need for expensive cubicle installations. Alumiline frames are of square aluminum tubing with smoothly rounded edges—rust-proof, easy to keep spotlessly clean; lightweight, but strong as steel. Stainless steel and the highest grade transparent plastic panels are used wherever design requirements indicate their need. Nurses note with pleasure that Alumiline is easy to move; that its attractive, graceful design assists in maintaining an appearance of neatness and order throughout the nursery. Please write for descriptive brochure and price quotations.



Ravenswood Bassinet; choice of drawer positions—side or end opening



Magee Combination Bassinet-Dressing Stand; complete nursery care

**A. S. ALOE COMPANY** and Subsidiaries—1831 Olive Street, St. Louis 3, Mo.  
Los Angeles, New Orleans, Kansas City, Minneapolis, Atlanta, and Washington, D. C.



**Q.**

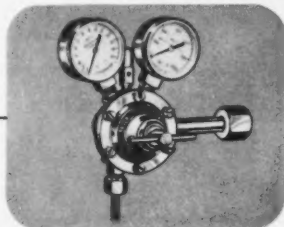
## WHY DO SO MANY HOSPITALS PREFER NCG OXYGEN THERAPY EQUIPMENT?

**A.**

Because they have learned that NCG equipment is designed with thoughtful understanding of hospital needs, it is carefully made to give long trou-

ble-free service—and that despite its excellence, it costs no more, often less, and always saves money in the long run. Here are typical examples:

### BETTER OXYGEN THERAPY APPARATUS LIKE THIS



#### BETTER, BUT COSTS LESS

NCG's new "6400" oxygen regulator represents an important advance in regulator design. It delivers the unvarying rate of flow characteristic of the finest 2-stage regulators, yet is comparable in cost to single stage types.



#### PREFERRED FOR CHILDREN

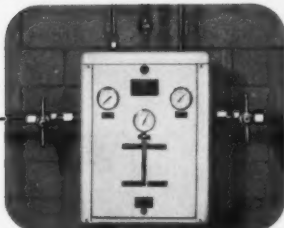
NCG's Plymouth Tent is widely preferred for children and infants because of its therapeutic merit plus its ease of operation, flexibility of use and low cost. Compact, lightweight, ideal for cubicles. Effectively used as a croup tent.



#### IMPROVED FOUR WAYS

NCG tent canopies combine long wear with convenient use. Metal suspension grommets prevent tearing. Front and back zipper openings permit positioning tent at either side of bed. Has gas-tight elastic sleeves, built-in thermometer.

### BETTER OXYGEN PIPING EQUIPMENT LIKE THIS



#### MORE ACCURATE CONTROL

Designed exclusively for hospital use, the new NCG "Even-Flow" control unit for piped oxygen is the most automatic, most fool-proof, most accurate yet devised. Assures constant, unfluctuating flow throughout the system.



#### EFFICIENT, INEXPENSIVE

This new, low-priced wall outlet takes up no more room than an electric light switch, yet offers all the utility of larger wall boxes. Has safety-keyed, quick-connect coupler with dust cap. Available also for N<sub>2</sub>O, air and vacuum.

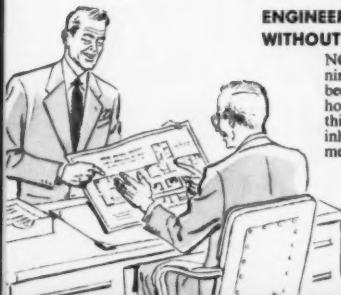


#### 3 IN 1 WALL OUTLET

This brand new outlet for operating rooms has quick-connect couplers for oxygen, N<sub>2</sub>O and vacuum—each individually safety-keyed. Available, too, for vacuum and oxygen, and vacuum only, for recovery rooms.

### ENGINEERING SERVICE WITHOUT COST OR OBLIGATION

NCG's expert assistance in planning oxygen piping systems has been found genuinely helpful by hospital executives. Inquiries on this and other requirements for inhalation therapy will receive immediate attention.



**NCG<sup>®</sup>**  
MEDICAL SERVICES

**NATIONAL CYLINDER GAS COMPANY**  
MEDICAL DIVISION  
840 North Michigan Avenue • Chicago 11, Illinois  
District offices in 52 principal cities

"NCG," "Plymouth" and "Even-Flow" are Trademarks

# *Enlarging the range of nutritional therapy*

Unrestricted use of foods in treatment where nutritional therapy is indicated . . . The priceless nutritive value of piping hot freshness and appetizing, full flavor . . . Special diets in unlimited variety delivered at the bedside kitchen-fresh . . .

Easy, speedy, economical handling of complicated and difficult feeding problems

. . . These are urgently desirable objectives readily and

economically achieved

with Ideal Extra Duty

Food Conveyors and

Ideal Special Diet Trays.



Write for complete specification data on this and other Ideal Equipment units which squarely meet across-the-board requirements in hospitals today.

Made only by the

**SWARTZBAUGH MFG. COMPANY**

Established in 1884—Toledo 6, Ohio

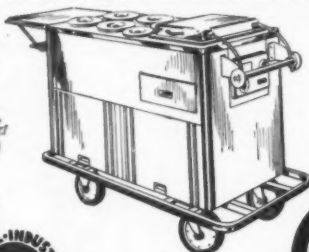
**FOOD CONVEYORS**

**TRAY CONVEYORS • HOT PACK HEATERS**

Distributed by the Colson Corporation, Elyria, Ohio; The Colson Equipment and Supply Company, Los Angeles, and San Francisco. In Canada: Canadian Fairbanks-Morse Company.

Over 2000 different combinations of food pans are possible with this Model 1003 Extra Duty Ideal Food Conveyor. Each 12 x 20 inch well accommodates 1 full size pan, 2 half size, 3 third size, 4 fourth size or 6 one-sixth size. Pans may be 2, 4, or 6 inch deep. Three 12

x 20 inch heated drawers give added capacity for special food. Standard Ideal Diet Trays will fit both top deck wells and drawers. Sag-proof top deck, easy handling, and cleaning, ample safety; automatic control are designed and built into this as into all other Ideal units.



Ideal special diet trays make it easy to serve any desired variety.



Ideal Hot Pack Heaters are available in two sizes.



More hospitals are equipped with Ideal Food Conveyors than all other makes combined.

***Ideal***  
**FOOD CONVEYOR SYSTEMS**  
*Found in Foremost Hospitals*

# GARLAND *the leader*



The New DINETTE  
Model 38

*Has the answer  
to your cooking needs!*

## Shown Are Only a Few of Many Basic Models

Garland leadership . . . proved again by the great variety of basic units and the hundreds of possible adaptations available! And that selection is the primary answer to greater efficiency, and greater economy in your cooking!

Whatever your food volume, whatever your food problem . . . you can do a faster, better cooking job with a Garland! For one of the many Garland ranges—or range adaptations—is certain to fill your individual needs.

And whatever Garland you select, you'll find the many exclusive Garland features mean better, more dependable performance. Yes, Garland is your best buy because Garland leads in value!

So see your Garland dealer! Comparison always makes Garland first choice!

*All Garland units are equipped for use with manufactured, natural or L-P-gas!*



Restaurant Range  
Model 83



Restaurant Range  
Model 84



Left to Right: All  
Hot Top—Open Top  
—Fry Top—Deep Fat Fryer—Broiler

**DM**  
PRODUCTS

**GARLAND**

**DM**  
PRODUCTS

Heavy Duty Ranges • Restaurant Ranges • Broiler-Roasters • Deep Fat Fryers  
Broiler-Griddles • Roasting Ovens • Griddles • Counter Griddles • Dinette Ranges

DETROIT-MICHIGAN STOVE CO., DETROIT 31, MICHIGAN





## Merry Fishless to You

### *New Fishless, Burpless Multivitamin Tablet*

CONTAINS B<sub>12</sub> PLUS 8 OTHER  
IMPORTANT VITAMINS

There's no fish-oil odor, taste or burp; no allergies due to fish oils with this hard compressed tablet. Thanks to synthetic vitamin A, there is no fish oil in DAYALETS.

These vanilla-flavored, sugar-coated tablets are easy to swallow, better tolerated by patients than soft gelatin capsules. Can't leak, won't stick together in the bottle. DAYALETS are supplied in bottles of 50, 100 and 250.

**Abbott**

Each DAYALET Tablet contains:  
 Vitamin A..... 10,000 U.S.P. units  
 (synthetic vitamin A palmitate)  
 Vitamin D..... 1000 U.S.P. units  
 (Vioosterol)  
 Thiamine Mononitrate..... 5 mg.  
 Riboflavin..... 5 mg.  
 Nicotinamide..... 25 mg.  
 Pyridoxine Hydrochloride..... 1.5 mg.  
 Vitamin B<sub>12</sub>..... 1 mcg.  
 (as vitamin B<sub>12</sub> concentrate)  
 Pantothenic Acid..... 5 mg.  
 (as calcium pantothenate)  
 Ascorbic Acid..... 100 mg.



NO FISH-OIL TASTE OR BURP

## Dayalets

TRADE MARK

(ABBOTT'S MULTIPLE VITAMINS)

*'Round  
the  
Clock*



## **B-P RIB-BACKS** *make it Easy*



*Easy* ON THE SURGEON because he is assured dependable blade performance by uniform sharpness—greater strength and rigidity.

*Easy* ON THE ASSISTANTS because dependable blade performance reduces time consuming delays detrimental to clocklike surgical procedure for the entire surgical team.

*Easy* ON THE BUDGET because the purchaser of B-P RIB-BACKS is assured proved cutting performance from every blade—and the maximum of satisfactory service . . . thus reducing blade consumption to an economic minimum.

*It's Sharp*

*Ask your dealer*

**BARD-PARKER COMPANY, INC.**

Danbury, Connecticut

For detailed information see our Catalog in 1951 HOSPITAL PURCHASING FILE

# "Doctor,

*The best man to answer this question  
is, of course, your family physician. We suggest  
that you ask him the next time  
you pay him a visit.*



# I'd like to know...

what is a

## NUTRITIONAL TIME BOMB?"

"Nutritional Time Bomb" is science's dramatic name for an equally dramatic discovery about diet...the discovery that injuries caused by mistakes in diet may not reveal themselves until years later.

Like actual time bombs, these injuries remain hidden and unrecognized, exploding into symptoms when it is too late to do anything about them. Thus, the dietary wrongs of childhood may be visited upon the adult.

Such scourges of later life as tooth decay, goiter, high blood pressure, heart disease, anemia and hardening of the arteries are not necessarily caused by present diet faults. They may be the delayed effects of earlier injury, where a dietary deficiency has existed too long.

A sound child body—the founda-

tion of a sound adult body—must be built from the food that goes into it. The true effect of a mother's care during childhood has only begun to be understood. And, since eating habits are formed in childhood, the conscientious parent can do much to insure the child against later penalties of wrong eating.

The protective foods should be used generously in the daily diet. Important among these are bananas—long prescribed by doctors as one of the first solid foods for infants. Bananas have a well-rounded supply of vitamins and minerals, and are distinctly beneficial in their action upon the digestive tract. Because of the many appetizing ways in which bananas can be served, as well as because of their nutritional value, they are now being more widely used than ever.

FOR HEALTH, EAT AND ENJOY A PLENTIFUL VARIETY OF THE "RIGHT" FOODS

UNITED FRUIT COMPANY



## How to have one less administrative headache



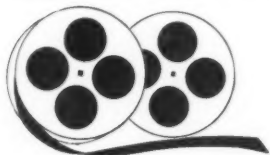
"Oxygen Therapy-wise" hospital administrators know the advantages of having an oxygen therapy department. Here are some of the services to users of LINDE Oxygen U.S.P. that can help you to organize and operate a smooth running oxygen therapy department in your hospital; just write or phone the nearest LINDE office.



**MEDICAL INFORMATION:** OXYGEN THERAPY NEWS; Medical Reprints; and "Bibliography on Oxygen Therapy."



**TECHNICAL INFORMATION:** "Oxygen Therapy Handbook"; OXYGEN THERAPY BULLETIN; Case Charts; Cylinder Flow-Chart Tags; Cylinder Contents Tags; Caution Signs; and Nursing Procedures.



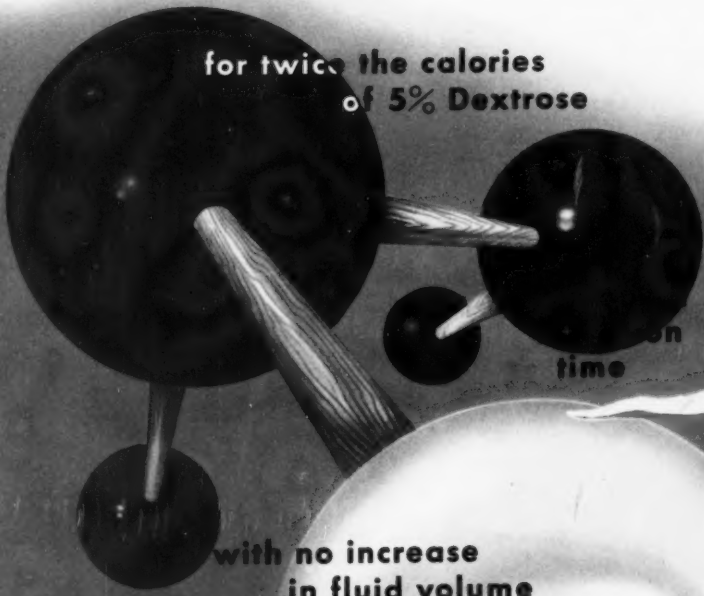
**MOTION PICTURES:** "Oxygen Therapy Procedures"; "Physiology of Anoxia"; "Oxygen Therapy in Heart Disease."



LINDE AIR PRODUCTS COMPANY, a Division of Union Carbide and Carbon Corporation  
30 East 42nd Street, New York 17, N. Y.  Offices in Other Principal Cities  
in Canada: Dominion Oxygen Company, Limited, Toronto

The term "Linde" is a trade-mark of Union Carbide and Carbon Corporation.





for twice the calories  
of 5% Dextrose

with no increase  
in fluid volume

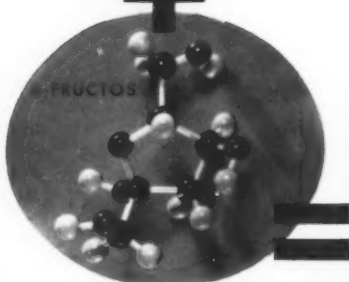
**PRESCRIBE**

**10% *Travert*® SOLUTIONS**  
(INVERT SUGAR)

**FOR IMPROVED  
CARBOHYDRATE ALIMENTATION**

# 10% *Travert*<sup>®</sup> SOLUTIONS

(INVERT SUGAR)



• •

*Travert* is available in water or saline  
in 150 cc., 500 cc., 1000 cc. sizes

products of

**BAXTER LABORATORIES, INC.**

Morton Grove, Illinois • Cleveland, Mississippi



## *Prescribe Travert*

- 1 to provide nutriment quickly
- 2 to spare protein by minimizing protein catabolism
- 3 to help maintain hepatic function
- 4 to inhibit ketosis

**PROVIDES TWICE AS MANY CALORIES  
AS 5% DEXTROSE...IN EQUAL INFUSION  
TIME... WITH NO INCREASE  
IN FLUID VOLUME OR VEIN DAMAGE**

## *— Another Baxter First*

*Travert*<sup>®</sup> is a sterile, crystal-clear, colorless, nonpyrogenic and nonanaphylactogenic solution. It is prepared by the hydrolysis of sucrose and is composed of equal parts of D-glucose (dextrose) and D-fructose (levulose).

• The limited rate of dextrose utilization has made impractical the administration of adequate carbohydrate for many patients. New *Travert*<sup>®</sup> overcomes this difficulty.

*Travert*<sup>®</sup> is assimilated at about twice the rate of dextrose. This means that a liter of 10% *Travert* (400 calories) requires no more time for administration than a liter of 5% dextrose (200 calories)—yet the patient gets twice as many calories!

Thus *Travert*<sup>®</sup> makes possible the administration of high caloric infusion with minimal discomfort and inconvenience to patients . . . and with the least amount of supervisory care.

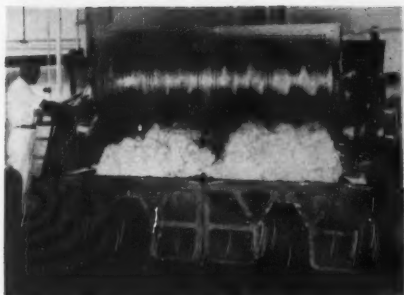
"*Travert*" is a trademark of BAXTER LABORATORIES, INC.

DISTRIBUTED AND AVAILABLE ONLY IN THE 37 STATES EAST OF THE ROCKIES (except in the city of El Paso, Texas) THROUGH  
**AMERICAN HOSPITAL SUPPLY CORPORATION**

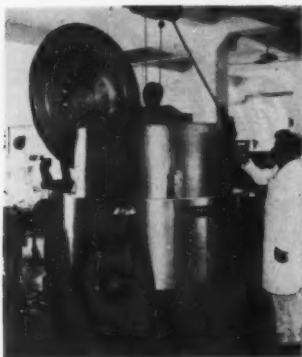
GENERAL OFFICES • EVANSTON, ILLINOIS

New "AMERICAN" Laundry  
**CUTS WORK WEEK 8 HRS...  
 WITH 4 LESS OPERATORS**

*at Peralta Hospital, Oakland, Calif.*



Merely pressing buttons automatically unloads washed work from CASCADE Automatic Unloading Washer into NOTRUX Extractor Containers in less than a minute, at Peralta Hospital. Automatic Control (at operator's left) takes washer through complete load cycle without attention from operator.



Loads are changed in NOTRUX Extractor by means of push-button operated electric hoist. Eliminates manual handling of work, saves time and labor in loading and unloading Extractor.

Efficiency-minded management of 150-bed Peralta Hospital modernized the laundry department with high-production, labor-saving AMERICAN equipment.

Our Laundry Advisor worked closely with Hospital officials; making a complete survey of the clean linen requirements . . . recommending new equipment necessary . . . submitting a floor plan layout of the laundry department.

Adoption of our Laundry Advisor's recommendations benefited the Hospital in the following ways: **reduced work week 8 hours . . . 4 less operators needed . . . less floor space required . . . lowered costs . . . linens returned to service in shorter time . . . better quality work.**

The services of our Laundry Advisor are available to hospitals, large or small, **without any cost or obligation whatever.** He will make a survey to determine the best method of solving your particular laundry problem . . . submit a suggested floor plan layout to assure fast, economical flow of work through the laundry. **WRITE TODAY . . .** for our Laundry Advisor to call at your convenience.

**REMEMBER . . . Every Department of Your Hospital Depends on the Laundry.**



The  
**AMERICAN**  
 LAUNDRY MACHINERY CO.

CINCINNATI 12, OHIO

TRUMATIC Folder at delivery end of SUPERSTYLON Flatwork Ironer automatically quarter-folds large linens lengthwise, enabling only one receiving operator to cross-fold and stack all work.





DIXIE CUP SERVICE IS

# One Way Service

**You don't have to wash Dixie Cups**

No sir! There are fewer trips back to the kitchen when you use Dixie paper service. Fewer hours at the dishwasher. In these days, when you have to get the most from every man-hour, you'll find it saves time and money to use one-way Dixie Cup service.

Dixies come in a wide variety of shapes and sizes... there's a Dixie Cup for 'most every need. Whether for cafeteria or bedside service, you'll find attractive, matching Dixie Cups a quick, easy service that saves both time and money.



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COLORS — a new, exclusive combination of beauty and durability  
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*Color-Trays* that are an exact match for your counter or table tops

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*Color-Trays* to inject that cheerful note in well-served or self-  
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*Boltabest Laminated COLOR-TRAYS' finish  
outlast ordinary trays by 4 to 8 years*

- In sizes 12x18, 14x18 and 15x20.
- Non-porous, Satin-smooth Surfaces
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**Indications:** Rheumatoid arthritis, rheumatic fever, acute lupus erythematosus, drug sensitivities, severe bronchial asthma, contact dermatitis, most acute inflammatory diseases of the eye, acute pemphigus, exfoliative dermatitis, ulcerative colitis, acute gouty arthritis, secondary adrenal cortical hypofunction.

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Tells all you will need to know about this amazing system—how it operates, how it may be fitted exactly to your needs. Write for your copy.

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Gentlemen: Please send me full information on Mengel Mahogany Flush Doors—both Hollow Core and Stabilized Solid Core.

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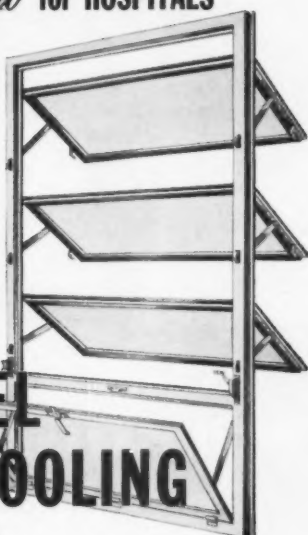
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Exclusive, patented Auto-Lok self-locking device automatically seals the window tight when closed... no wearing parts, nothing to adjust.



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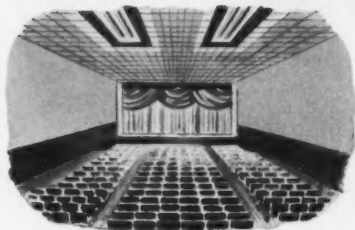
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before you design, build or remodel. Ask us to send you a copy of this booklet.  
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SEALED LIKE A REFRIGERATOR

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# Do you know these facts about acoustical materials ?



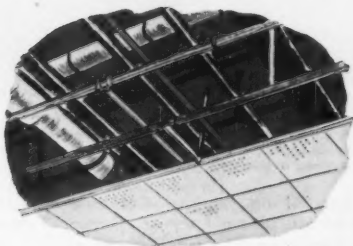
**Q.** How much acoustical treatment does an auditorium need?

**A.** Usually, acoustical problems in auditoriums can be corrected with a minimum of acoustical materials. Where echoes and reverberations are very bad, however, it may be necessary to treat some wall areas as well as the ceiling. The acoustical contractor is always careful to avoid overtreatment which might result in a "dead" room.



**Q.** Can acoustical materials be cemented directly to concrete?

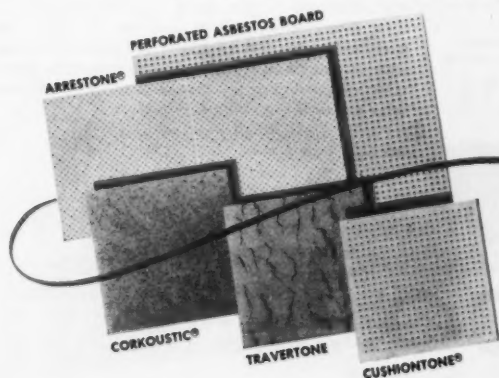
**A.** A reasonably smooth concrete ceiling is an ideal base for cementing acoustical materials. Rough, uneven surfaces usually require wood furring strips. It's important that new concrete be thoroughly dry and that loose paint and oil are removed before the application of acoustical materials.



**Q.** How do you treat a "cluttered" ceiling?

**A.** When there are too many pipes and ducts overhead, a new ceiling is suspended below them. One method is to suspend a metal pan acoustical material, like Armstrong's Arrestone, from the ceiling by metal hangers. Another way is to install a false ceiling of plaster or gypsum as a base for the application of acoustical tiles by cementing.

**FREE BOOKLET, "How to Select an Acoustical Material,"** answers many questions about sound conditioning. Write to Armstrong Cork Company, 5712 Stevens St., Lancaster, Pa.

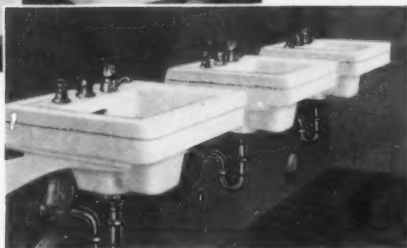


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*Crane Norwich lavatories at Royal C. Johnson Veterans' Hospital are highest quality vitreous china with exclusive Magiclose faucets that turn so effortlessly that wear and consequent dripping are greatly reduced.*

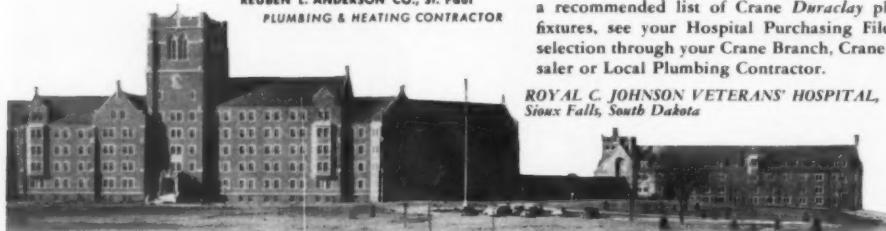
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GENERAL CONTRACTORS

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"But Gentlemen—How old will it be tomorrow?"



The gentleman above is asking a very pertinent question. The other board members, in the interest of economy, are about to *vote down* his recommendation to put individual room temperature control in their new hospital.

*"Mark my words," he's saying, "this new hospital of ours will soon be OLD-FASHIONED—unless it has a thermostat in every room. Individual room temperature control is a must for modern hospitals. Let's build a hospital for today that can be used for tomorrow, as well."*

Is he exaggerating? Definitely not! As most hospital administrators know—it is becoming more and more routine in medical practice to give each patient the *exact* room temperature he needs to accelerate his recovery. And you can do this *only* with individual room temperature controls. No other system can maintain different temperatures in different rooms *at the same time*; or compensate for the effects of wind, sun,

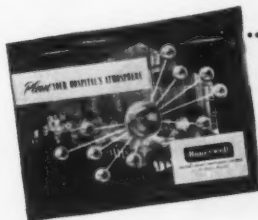
open windows, and number of room occupants, at all times, anywhere in the hospital. It's just smart business to install individual controls *when your hospital is being built*. Doing it later costs substantially more money.

For complete facts on Honeywell Controls for your new hospital, call your local Honeywell office—there are 91 of them located in key cities all over the country—or mail coupon today!

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Please send me literature and full details on individual room temperature control for hospitals.

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City \_\_\_\_\_ Zone \_\_\_\_\_ State \_\_\_\_\_

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## **on Hospital Electrical Planning for Architects and Engineers**

Are you planning a hospital? This new data book for Hospital Architects and Engineers outlines the steps in designing the electrical distribution system and reviews the electrical requirements with plan views and riser diagrams for a number of representative hospitals.

Using a 100-bed general hospital design as typical, a room-by-room electrical analysis is made, load calculations by rooms and by panelboards are shown, and feeder and conduit sizes are listed. Kva demand calculations and transformer application calculations are summarized for this example.

The vital X-ray Department is fully covered by recommendations on X-ray planning and descriptions of the equipment for various hospital sizes. Another section is devoted to signal systems.

If you have not yet received your copy of this helpful data book, please contact your Westinghouse representative.

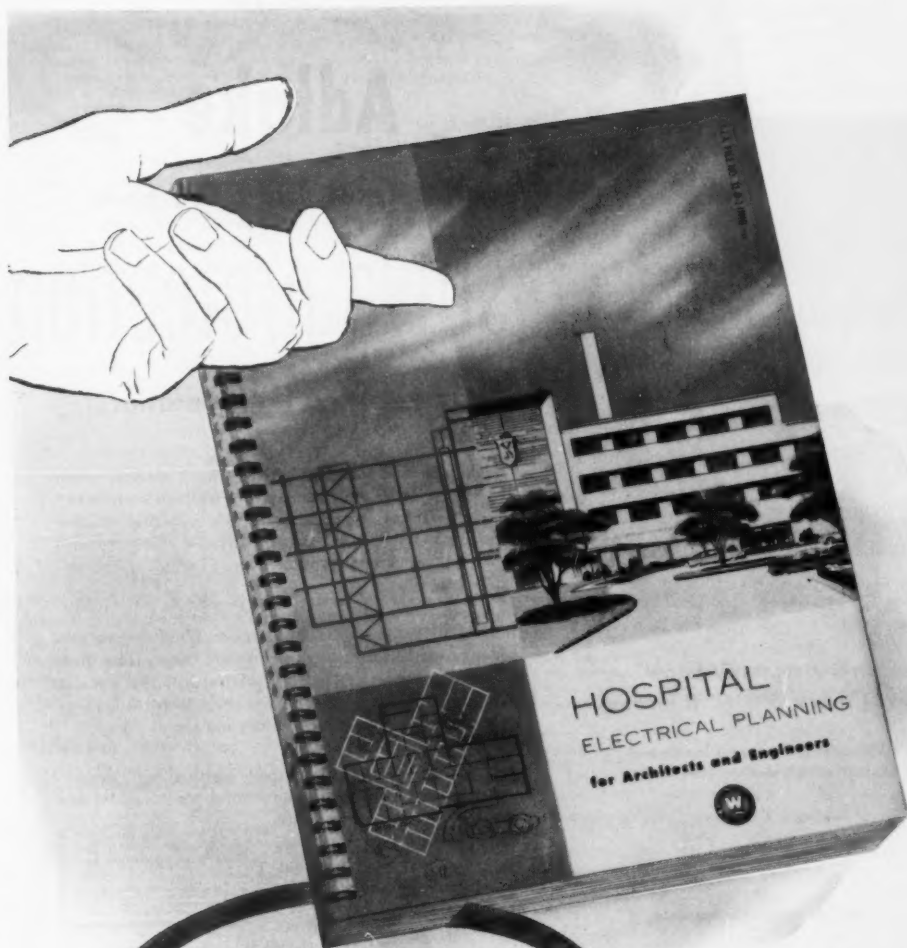
J-94892

YOU CAN BE **SURE**... IF IT'S

# **Westinghouse**

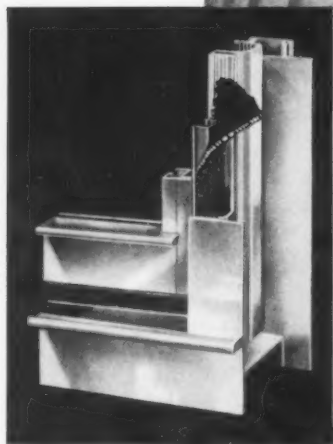
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*Conforms to U.S.  
Public Health Service  
Recommendations!*





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**Woven-Pile Weather Stripping and  
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• Finger-tip Control

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You can depend on complete weather-tightness when you specify ADLAKE Aluminum Windows — for every ADLAKE Window combines sturdy woven-pile weather stripping with exclusive patented serrated guides, to form a perfect baffle against infiltration of wind, water and cold!

There's no "maybe" about it! ADLAKE Windows are subjected to air and water tests *even more rugged* than those given at Pittsburgh Testing Laboratory! Yes, ADLAKE Aluminum Windows not only meet A.W.M.A. Quality Specifications, but actually go beyond them!

And ADLAKE Windows keep their weather seal, beauty, and finger-tip operation for the life of the building! What's more, they require no maintenance other than routine washing—actually pay for themselves through the saving in maintenance costs!



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The MODERN HOSPITAL

## Small Hospital Questions

### Charge for Second Round?

Question: If a patient must be returned to the operating room following tonsillectomy and the entire surgical crew and anesthesiologist are called on duty at 3 a.m. to assist in stopping a hemorrhage should the hospital charge the patient the same rate as was originally filed for these services?—B.D., Ind.

ANSWER: Many hospitals consider the circumstance described here simply an unforeseen continuation of the initial surgery and do not make an additional operating room charge. However, a problem develops in connection with this policy: Where should the line be drawn? What is to be done about the patient who is discharged following surgery and then develops some bleeding or other complication and must return to the hospital for an additional operating room procedure? Actually, the only difference between this and the situation described in the question here may be one of time. Yet most hospitals would charge an additional fee for use of the operating room in the case of patients who had been discharged following the initial operation.

Probably the wisest procedure would be to decide each such case on its own merits after consultation with the surgeon. Certainly, good public relations would indicate a liberal policy in all such cases, yet hospitals cannot afford to lose needed revenue today.

### Solicitation Practices

Question: We are planning a fund raising campaign and one of our board members has suggested that we send a solicitation letter to all the pharmaceutical companies, hospital supply houses, and other manufacturers and distributors with whom we are doing business. Other members of the board feel this is not a wise procedure. Can you tell us what the common practice has been among hospitals elsewhere?—S.J.O., N.Y.

ANSWER: While there are still some hospitals which solicit gifts and contributions from suppliers, it is increasingly recognized that this is an unethical and uneconomical practice in the long run. It is unethical because the supplier doing business with a hospital may feel under pressure to contribute when he receives such a solicitation; the contribution is therefore something less than voluntary. It is uneconomical because, in the long run, corporate contributions to hospital campaigns are considered a part of the manufacturer's or supplier's

cost of doing business and are added to the price of the merchandise. Thus one hospital's campaign gain is likely to be all hospitals' financial loss.

### Division of Funds

Question: Possibly because of the high cost of living and the shortage of money among our patients, we seem to be engaged in a race with the medical staff to see who gets the few dollars the patient may have at the time of his hospitalization.

We do not generally request an initial deposit, but we do ask for a payment within five days or at the time of discharge, whichever is earlier. Now we find that some of the doctors are asking for a "payment on account" at the time of admission to the hospital—a practice which frequently leaves the hospital "holding the bag." It has been suggested that the medical staff be requested to adopt a regulation or principle somewhat as follows:

"Inasmuch as the hospital and the staff have a common purpose of maintaining a hospital for the benefit of the patients and the community, cooperation is indicated in the important matter of an equitable division of funds which patients in moderate circumstances are able to pay. Across the nation it is generally understood that payments to community hospitals should come first in order that their doors may be kept open and so that charitable funds may not be used for the care of patients while the income of the doctors is being unduly increased. It is therefore deemed to be unethical for a member of the staff to promise concessions concerning the hospital bill unless he is specifically authorized to do so or to demand payment for services while the patient is in the hospital. By the observance of this principle the hospital is given an opportunity to present its bill and make suitable arrangements for payment by the patient."

Can you suggest any improvement in the foregoing? Any comments or advice you may make would be greatly appreciated.—R.N.B., Tenn.

ANSWER: We agree that some steps must be taken to protect the hospital in

these instances; certainly no staff member should ever promise concessions on the hospital bill without specific authorization, as you point out.

Our only suggestion here has to do with the method of presenting the problem to your staff. If possible, it seems to us that a few leading staff members should be thoroughly apprised of the problem in all its details in advance of any formal discussion so that the necessary regulatory action would emerge from the staff itself as a self-control measure rather than from the hospital.

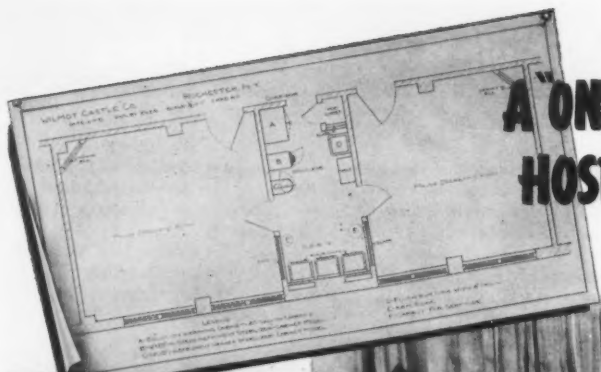
### Need for Special Hospital

Question: I wonder if you can inform me if a community which draws from 75,000 population could support a 20 to 30 bed women's hospital, primarily for obstetrics and gynecology? What would be the best general plan for such a hospital? How much would it cost to construct? Could you give a rough estimate of the monthly operating cost? I realize these are variable factors, but any information you can furnish would be helpful.—D.F., N.Y.

ANSWER: Authorities in the hospital field are uniformly convinced that no hospital should be built in any part of any state unless it fits into the master plan or hospital construction program for the state that has been developed by the state department of health under the Hill-Burton hospital construction program. It would be impossible to answer the question here, at any rate, without a complete study of the area involved; there are so many factors that affect the ability of a hospital to operate in any area that no one could possibly have an intelligent opinion unless he had made a thorough study of local conditions.

Furthermore, it is agreed by most hospital authorities that "specialty hospitals" like the one contemplated here should not be built. Facilities for these and all other types of patients should be provided instead, it is felt, as units of general hospitals. Before this plan is carried any further, it is suggested that the whole subject should be reviewed with hospital planning authorities in the appropriate state health department. If local general hospitals are not providing adequate facilities in these specialties, thought should first be given to improvements or additions to existing hospitals.—E. W. JONES.

Conducted by Jewell W. Thrasher,  
R.N., Frazier-Ellis Hospital, Dothan,  
Ala.; William B. Sweeney, Wind-  
ham Community Memorial Hos-  
pital, Willimantic, Conn.; A. A.  
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Maine, and others.



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... with many Castle assists

Canada's newly completed KITCHENER-WATERLOO 347 bed hospital, widely publicized as the last ward in modern construction, facilities and appointments, selected Castle Sterilizers and Surgical Lights further acknowledgment of Castle's established leadership.



Sub-Sterilizer Room Installation.



Central Sterile Supply, with sterilizers cycled by Thermatic governors with remote control supervision.

An innovation in having sub-sterilizing and scrub-up facilities in one room—as recommended by Castle, is a featured facility most favorably commented upon.

- Direct passage between corridor and sterilizers eliminates unauthorized traffic through operating rooms.
- Scrub-up sinks are placed on outer wall; sterilizers on inner wall nearest to nurse traffic. This saves nurses many minutes and steps in every operation. Surgeon's scrub-up is undisturbed, yet he may observe pre-operative preparation of patient through transparent panel.
- Only 3 sterilizing units required!—Castle Hi-Speed Emergency Sterilizer . . . Castle Pressure Instrument Washer-Sterilizer . . . Castle Solution and Blanket Warmer. All dressings, utensils and flasks solutions and distilled water supplied by Central Sterile Supply.
- ARCHITECTS: Govan, Ferguson, Lindsay, Kaminker, Maw, Langley, Keenleyside—Toronto.

\*The Canadian Hospital, Vol. 28, No. 7, p. 79, July, 1951.

We invite your request to place our Planning Engineers at your disposal, gratis . . . WRITE TODAY.

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*Curity* Sutures are processed from selected cat gut, and totally chromicized by an exclusive method for reliable absorption rate. They have the right smoothness for sure knot tying. Their pliability means proper knot seating. They come from the laboratory which has made major contributions to suture making.



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Needles shown  
approx.  $\frac{2}{3}$   
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73 Large $\frac{1}{2}$ Circle Eyeless USES: GENITO-URINARY, Obstetrical, Gynecology, etc.	83E Large $\frac{3}{8}$ Circle Eyed USES: OBSTETRICAL	87E Small $\frac{3}{8}$ Circle Eyed USES: EMERGENCY
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12 Cutting Needles. Available in combination with various suture materials.

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11 Small $\frac{1}{2}$ Circle Eyeless USES: GASTRO-INTESTINAL, TONSIL & ADENOID, etc.	23 Large $\frac{1}{2}$ Circle Eyeless USES: OBSTETRICAL, PERI- TONEAL, Gynecology, etc.
12 Medium $\frac{1}{2}$ Circle Eyeless USES: BLOOD VESSEL UGA- TURE, Gastro-Intestinal, etc.	30 Small $\frac{3}{8}$ Circle Eyeless USES: EYE
13 Large $\frac{1}{2}$ Circle Eyeless USES: GASTRO-INTESTINAL	48 Straight Eyeless USES: GASTRO-INTESTINAL, Plastic, Skin Graft.

## 10 Taper Needles.

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A thorough survey of surgical practices and preferences in representative hospitals has resulted in a new line of needles keyed to modern needs.

These two groups of twenty-two Curity needles cover virtually every surgical requirement . . . and greatly simplify the selection problem for surgeon and hospital alike. Only the major uses are indicated in the charts. Other uses are limited only by the surgeon's choice.

If you are not yet familiar with the new Curity Needle Line, a Curity Representative will welcome the opportunity to discuss it with you.







## wire from **Washington**

### **V.A. HOSPITALS IN TROUBLE**

Veterans Administration P.N. hospitals again are in trouble—too many patients, too few beds. The present crisis is a by-product of Public Law 239, passed by the last Congress. This provides that a service-connection may be presumed for all psychosis cases developing within two years after the veteran's discharge, either from World War II or Korean service.

The pinch comes from the degree of hospital service accorded to service-connected cases, in contrast to those with no service connection. If the sickness or injury can be shown to be service-connected, the man is entitled to immediate hospitalization if this is required. But if there is no service connection, the man may be allowed to enter a hospital—but not to receive outpatient care—only if there are extra beds. In practical operations, nonservice cases make up the waiting lists, service-connected are taken care of promptly.

As soon as the new law became effective, most of the 9000 psychoneurotic cases waiting for hospitalization could be assumed to be service-connected, and V.A. was expected immediately to find room for them. But law or no law, there wasn't much V.A. could do, because all of its 53,000 P.N. beds are filled, and staff shortages make it unlikely more beds can be put into operation.

Best solution V.A. could manage was to delay issuance of regulations under the law while attempting to do something about the 9000 or so men who, under the law, were entitled to immediate hospitalization or outpatient treatment.

### **U.M.W. HOSPITALS**

Before long the United Mine Workers union will be well started on its own system of hospitals. According to officials of U.M.W.'s Welfare and Retirement Fund, there was no other course. In some areas there were inadequate hospital facilities, or none at all. In others, the beds there were did not meet U.M.W.'s own standards, and U.M.W. considered some prices out of line.

Welfare fund officials said that local physicians would be used to the extent possible, but that they would not hesitate to bring in outsiders if necessary.

A decentralized system has been set up to handle construction and operation, but essential control will remain with the fund. Already land has been obtained at Harlan and Wheelwright, Ky., and Beckley and Williamson, W. Va. Six other projects also are planned in mine areas where hospital facilities are a problem.

Medical administrator of the three state memorial associations which will handle the hospitals (Virginia, West Virginia and Kentucky) will be Dr. Frederick D. Mott, who spent many years with the U.S. Farm Security Administration but more recently has been deputy minister of health for Saskatchewan, Sask.

The U.M.W. Fund, financed by a 30 cent per ton royalty on all coal, provides pensions and health and welfare benefits for U.M.W.'s 600,000 members and their families. Although

the fund was nearly broke a few years ago, now it has a substantial surplus (around \$100,000,000) and is perfectly capable of building and operating any hospitals it decides it needs.

Officials have not entirely abandoned hope, however, of making use of Hill-Burton grants in some areas. Basically, the problem here is that U.M.W. hospitals of necessity will have to give preference to union members, whereas H.B. hospitals must be open to the public with no preference. It is possible that this requirement can be satisfied by the union in areas where U.M.W. members make up almost all of the population.

### **APPROVES HEALTH PLANS**

Another large group of health plans, held up for months, has been given the green light by Wage Stabilization Board. The hospital, medical and surgical plans, negotiated into union contracts, were tied up while W.S.B. attempted to determine if the plans were inflationary, therefore would have to be counted under various wage ceilings.

Without stating any permanent policy, W.S.B. decided to permit any plans to function if they met simple requirements. The primary guide is that the plan may be no more than an industry or geographic extension of existing plans.

At the same time, W.S.B. was studying conflicting recommendations from a panel of experts who had studied the problem for many months. Labor and public members of the panel recommended that any of the usual type of plans be allowed to operate, regardless of whether it was an extension of existing programs or something new in an industry or areas. The industry members, however, opposed this wide grant of authority as inflationary, and recommended a number of restrictions.

At this writing, W.S.B. has not made a decision on the conflicting suggestions, but the log-jam of programs is clearing away under the industry-or-area-extension interpretation.

### **SERVICE TO DEPENDENTS**

Preparing for hearings when Congress meets in January, the staff of the Senate health subcommittee is gathering together all available information on the problem of providing health and hospital service to dependents of enlisted servicemen.

Hospitals are familiar with one effort in this direction during the last war—the E.M.I.C. program, providing emergency maternity and infant care for enlisted men's wives and children. One of the proposals before the committee would set up a somewhat similar plan, but with 50-50 matching grants to the states, and with a child regarded as an infant through his fifth year.

The same bill that advances this (S. 2337) also would allow all dependents of servicemen, regardless of age, to receive free hospitalization, with state and federal government dividing the costs.

Assisting the committee staff in preparing for hearings are U.S. Children's Bureau, which is anxious for action as

soon as possible, and U.S. Public Health Service. Also helping out with information and advice are officials of American Hospital Association, American Legion and a few other veterans' groups, several parents' associations, Congress of Industrial Organizations and American Federation of Labor.

Red Cross already has turned over what information it has on the present need for the grant programs, as evaluated through requests from several states.

Unless the armed forces are greatly increased, with fathers and other older men brought into service, these hearings may be expected to stimulate a loud and long argument. Critics of the plans claim that (a) they may be needed some time, but that time hasn't come because of the comparatively young age of most servicemen, and (b) the so-called "demands" for help are largely synthetic, amplified for political reasons.

### PRIORITIES

Hospital construction already under way is assured enough steel and copper wire to continue through the first quarter of 1952 but might be held up by D.P.A.'s failure to approve request for additional allotments of copper brass mill products. Following a mid-November meeting at which D.P.A. allocations board heard demands of all claimant agencies, hospitals were given an additional 7500 tons of carbon steel (P.H.S. had asked for 10,000 tons) and 3500 tons (of 5800 requested) of structural steel. The board also granted 60 per cent of the requested additional tonnage of copper wire products but failed to add anything to the brass mill products allotment.

P.H.S. officials say this could slow up or hold up going projects in the first quarter. If it doesn't, they estimate now as many as 50 new hospital projects may start in this period.

Problems in hospital maintenance, repair and operation should be eased slightly next year. Announcement is expected any day that the maximum MRO expenditure, without special authorization from Washington, has been increased from \$750 to \$1000.

Hospitals are cautioned, however, that they are still not allowed to group together a number of MRO's, each totaling less than \$1000, in order to exceed the maximum figure.

As a direct reaction to material shortages, the hospital construction industry has inaugurated its own campaign to conserve metal. According to Public Health Service, a re-

duction of approximately 35 per cent has been made in quantities of steel, copper and aluminum needed for hospitals and related health facilities.

P.H.S. credited development of new construction standards to joint efforts of state and local agencies, hospital architects, Defense Production Administration and National Production Agency.

Keeping continuous check on use of critical metals will be a steering committee for conservation, composed of architects, industry representatives and officials of Federal Security Agency and Defense Production Administration. Representing Division of Civilian Health Requirements, Public Health Service, will be Wesley E. Gilbertson, chief of the division. The alternate representative from the division is John H. Ludwig, chief of the Technical Operations Branch.

### FEDERAL HOSPITAL COUNCIL

Although two new appointments have been made to the Federal Hospital Council, top federal advisory board for the Hill-Burton program, two vacancies still exist. Yet to be named are the rural and labor representatives. The new hospital representative is Dr. Albert W. Snoko, physician-administrator of Grace-New Haven hospital at Yale. The new medical representative is Dr. James W. Graham of Kansas City.

### BLOOD TYPING

After several months' study of the problem, Federal Civil Defense Administration has come out in opposition to a national mass blood typing program. The subject has been debated heatedly since a national veterans' association launched a series of mass typing campaigns in a few selected cities.

C.D.A. raises these specific objections:

1. Mass blood typing, done carefully and accurately, would be expensive and would use money and energy that could be applied to other phases of the civil defense program.
2. Any effort to give specific blood group transfusions following an attack would complicate the work of hospitals and first-aid stations and prevent a rapid flow of blood to thousands of patients.

Instead, the federal officials recommend that each area build up a reservoir of group O volunteers, who would be called on in case of an emergency. In addition, a "reasonable number" of other volunteers could be classified.

### A.H.A. MOVE PENDING

Chicago.—Consideration of a plan to move American Hospital Association headquarters to Princeton, N.J., was held up last month when trustees of Westminster Choir College decided not to sell their Princeton property at the present time. However, A.H.A. trustees will meet at Princeton early this month to inspect the Westminster buildings and decide whether the college would make a suitable permanent headquarters for the association if it should become available for purchase.

Following several months of negotiation between college and A.H.A. representatives, the decision not to sell was made because of uncertainty about the college's ability to build now on property that has been donated to it, an A.H.A. official reported here.

Located near the campus of Princeton University, Westminster Choir College consists of an administration and

classroom building and several residence facilities, all of which were to be purchased by the association at a price reported to be "slightly less than \$1,000,000." As outlined by Executive Director George Bugbee in a proposal submitted to association trustees, advantages of the location included ample facilities for a greatly expanded program of institutes and educational meetings, and reduced travel time for headquarters staff members, many of whose activities are concentrated in the East.

Under the proposed plan, the present headquarters building here would be sold and the staff would move to Princeton, where association activities would be conducted in the college buildings. The Washington service bureau of the association would be retained, it was explained. The project was to be financed as far as possible by contributions, with a minimum of borrowing, the proposal indicated.



# Looking Forward

## Heal the Sick

TWO church-connected publications, *The Churchman* and *Report From the Capital*, a newsletter published by the Baptist Joint Committee on Public Affairs, have been worrying recently about the amount of Hill-Burton money allocated to Catholic hospitals. "The sum total of government grants to Roman Catholic hospitals has been astounding," said *The Churchman* for Oct. 15, 1951. "To date Roman Catholic hospitals under the Hill-Burton Act have received more than one-sixth of the total government grants to hospitals of every kind," echoed the *Report*. "The Roman Catholics have received more than seven times as much for their hospitals as all other church hospitals have received for theirs. Do they expect the government to continue such favoritism?"

In hearings before the Senate District of Columbia Committee, the Baptist Joint Committee also testified against a bill to provide special aid for District hospitals. The *Report* commended Sen. Olin Johnston of South Carolina, who opposed the bill, for "fidelity to his oath of office to uphold the Constitution." The bill, it develops, would have provided funds for new buildings for Providence Hospital, a Catholic teaching institution.

The reference to Senator Johnston's oath to uphold the Constitution would indicate that opposition to the District grant was based on the First Amendment, stipulating that "the Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof." In the case of Hill-Burton funds, however, the objection seems to be, not that federal money has been allocated to "establishments of religion," if church hospitals can be so described, but that more money has gone to the hospitals of one Church than to others.

One of these publications suggests that this is the result of "government favoritism." This is absurd. The provisions of Public Law 725 and the regulations under which the act is administered would make it virtually impossible for hospital projects to be approved or rejected for sectarian reasons—even if anyone connected with the administration of the law were so inclined, which is doubtful. The only basis for approval is the need for hospital beds and services; the fact that Catholic institutions have received more money than some other groups can indicate only that the Catholic Church, through its existing hospital facilities and organizations,

has been better prepared to meet the needs and render the services.

Is this bad? If it is, so was Christ's admonition to the healers, as reported by St. Luke: "Into whatsoever city ye enter and they receive you, heal the sick that are therein."

## What Is a Woman Profited?

THE conventional picture of the American wife is that of the little woman busy and happy at her homemaking and child-rearing tasks—always prettily aproned, if we are to believe our popular magazine art, and exclaiming joyfully from time to time throughout the day about the manifold wonders of her ironers, dishwashers, detergents, cake mixes, frozen fillets and all the other marvels that are whiter, brighter, quicker and tastier than anybody else's marvels, according to independent surveys.

The fact is that this electro-chemical dreamland is by no means the whole, or even in many cases the principal, preoccupation of American wives. Nearly a third of them, to begin with, are away all day, working like their husbands at money-making jobs. Most of those who do stay home are keeping a watchful eye on their husbands' jobs, if not actually plotting and maneuvering the next steps in their careers. That gleam in the little woman's eye at any time may be pride in her Little Jumbo All-Purpose Mixer, or it may be crafty anticipation of what she is going to say to the president, or the president's wife, at the company cocktail party. Her mind is ever focused on a better job, more money and a bigger, shinier environment. The business wife has become a recognized factor in our economic system, playing her part in company politics, conventions, entertainment and other aspects of the modern business rat race. In some occupations today, in fact, an unattractive, antisocial or noncompetitive wife is a greater handicap to a man's career than illiteracy.

This is probably not true of hospital administration but as human relationships become increasingly important in the effective discharge of administrative responsibilities, there is no question that the right kind of wife can be increasingly an asset to the administrator. In the tightly knit social life of some hospital communities, for example, where trustees speak only to doctors and doctors speak only to one another, the administrator can easily be frozen out of all but formal

contact with both groups—thus possibly losing important channels of communication and perhaps limiting his effectiveness. In this kind of situation an intelligent, socially mature wife can often maneuver her husband's way to success where his technical knowledge and administrative skill alone would fail.

To know how important the wife may be in the personal career of a hospital administrator who is bucking for a new job, one has only to observe some of the better operators in action at hospital conventions—and chart the results. Circumstances such as these may be hard on administrators without wives or with anti-social wives, and on women administrators who are not themselves socially aware or qualified. But we may as well face it: The way things are, they may have to be better administrators today to succeed as well as the man with a good "company wife."

The chief danger of this kind of social conniving, in the hospital and in business, is not so much that it can easily become a substitute for good work and a mask for incompetency as that it tends to put a dollar sign on friendship—a form of moral deterioration that is already far advanced in business and should certainly be resisted in the professions and professional institutions. The shared interest of husband and wife in material or professional success and their willingness to work hard together to achieve it are perfectly wholesome—within reasonable limits. When this interest governs every act of both husband and wife, however, success may be gained but the human beings themselves are lost.

### John Storm

THE death on Nov. 4, 1951, of John M. Storm, editor and business manager of *Hospitals*, was a severe loss to the American Hospital Association, hospital journalism and the entire hospital world. Coming to the editorship shortly after the change in association administration in 1943, John Storm guided the sound growth of *Hospitals* in size, editorial strength, and usefulness to association members. He helped to create the new journal *Trustee*, a lasting contribution to the voluntary hospital system.

In many of our common interests and efforts, John Storm was our competitor. Here at *The MODERN HOSPITAL* we regarded him as a good one—tough in competition, but fair and always approachable and friendly. We shall miss him.

### Doctors in Politics

FOR the last three years, the political action program of the medical profession has been a subject of interested discussion and debate among doctors, hospital people and their friends. In presenting the article beginning on page 51 of this magazine, *The MODERN HOSPITAL* does not question the propriety or advisability of political action by doctors, nor the desirability of the over-all aim of the action described here—turning back the threat of socialized medicine, an objective we wholeheartedly support. We do, however, feel that

a question should be raised about some of the means and methods that have been used and are described in detail in this article.

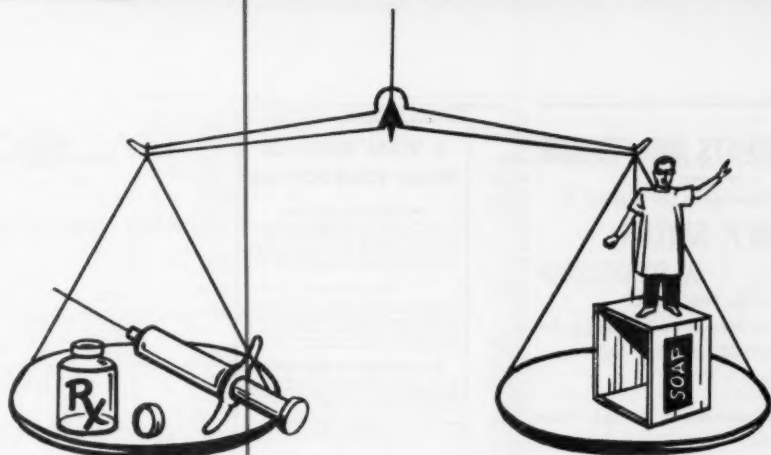
Our own concept of the doctor's political responsibilities was summarized in a recent statement by an official of the American Medical Association, Dr. H. Boyd Stewart, chairman of the A.M.A. section on anesthesiology. "The physician has a professional obligation to be a part of all educational, religious and civic activities," Dr. Stewart said in an address at the A.M.A.'s annual session at Atlantic City last June. "In our complex way of living these days, at a time when every walk of life has some connection with politics and when politics seem to dominate the very direction and progress of all professions and business enterprises, it strikes me as rather ridiculous for physicians on the whole to feel it is beneath their professional dignity to take any part in politics. As an important segment of society, holding a very high public esteem, I feel we not only can but we are morally obligated to become active in a dignified way. I surely do not mean to recommend or condone entering politics as a pressure group for selfish aims. There are two very good reasons, as I see it, for taking part in politics. First, we must do what we can to interest and support competent and honest men in government. Second, we must protect ourselves and the public from unwise legislation and political action. The very survival of democracy and a revival of honesty and dignity in government require that everyone take an interest in politics. . . . If we keep our own house in order and refrain from the dishonest practices so prevalent in many other walks of life, it could be that organized medicine would emerge as a lighthouse in a stormy and deranged society."

### Social Medicine

IN THIS issue, *The MODERN HOSPITAL* introduces a new subject heading, Social Medicine, under which we shall present articles dealing with preventive medicine, home care, rehabilitation and the social and circumstantial aspects of hospitalized illness. These services must be developed, it has seemed to us, as a necessary and logical extension of hospital service as we know it today, in keeping with the growing awareness in medicine that the patient's whole life circumstance, and not just the specific disease process, must be considered in making the diagnosis and carrying out the treatment.

It is appropriate that the first article to appear under this heading is a contribution from Dr. E. M. Bluestone, for many years director and now consultant to Montefiore Hospital, New York City. At Montefiore Hospital, Dr. Bluestone has introduced and developed many new services designed, as he has expressed it, "to deal with the complication of fear in hospitals." His address to the International Hospital Congress at Brussels last summer (page 61) comprehends changes in our society that foretell what medical and hospital service may be in years to come.





## Can **POLITICAL** MEANS gain **PROFESSIONAL** ENDS?

*He has the right and duty to speak up  
on political issues that concern him,  
but can the doctor afford to use  
the politician's tactics?*

*What happens when a clean-hands  
profession gets into a dirty-hands  
business?*

R. M. CUNNINGHAM Jr.

**H**OW doctors in Western Pennsylvania and New York State organized political action committees to back certain candidates and oppose others in congressional elections is told in a confidential report that is being circulated among medical society officials and is said to be a blueprint for political organization of the medical, nursing and hospital professions in the 1952 presidential campaign. The report is unsigned, but the method suggests the fine California hand of Whitaker and Baxter, the American Medical Association's politically wise public relations virtuoso. Whether or not it is actually theirs in this case, the technic was once described in its simplest terms by Leone Baxter herself: "Show them the devil and lead them to the altar," she said.

It might also be put the other way around. Few people would question the doctor's right, as citizen, to express himself politically, to organize for the achievement of political aims he regards as desirable, and to speak up on issues, such as socialized medicine and compulsory health insurance, which concern him professionally. But some

doctors and their friends do question whether it is right to use the county medical society, presumably a scientific and educational organization, for political purposes; and whether the sacred patient-physician relationship should be subverted to political ends, as it plainly was in the Pennsylvania and New York campaigns; and whether the doctor should lend himself to political statements of questionable truth, however well-intentioned, and, finally, whether the doctor is on solid moral ground when he embraces as his companions in "healing arts committees" organized for political reasons the chiropractor, the

osteopath and the optometrist, whose standing as healers he has consistently belittled at all other times.

Whatever the finer points of its moral quality, however, the method was unquestionably effective in the fall of 1949. In the 26th Pennsylvania district, Healing Arts Candidate John P. Saylor (Republican) beat his opponent by 8488 votes in an off-year election in which the vote cast was 99 per cent of the total in the last presidential election and the switch from Democratic to Republican columns between elections totaled an impressive 20,544 votes! In New York State, the doctors and their fellow

**TO MY PATIENTS AND FRIENDS**

I am Very Interested in the Election of  
**JOHN P. SAYLOR**  
**AS CONGRESSMAN**  
 From Our 26th District

Will You Please Do Me a Favor By Going to the  
 Polls on **SEPTEMBER 13, 1949**, and Voting  
 For John P. Saylor?

If You Need Transportation on That Day, Please  
 Notify Me at Once.

Signed

**A VITAL MESSAGE FROM YOUR DOCTOR**

Political Medicine is Bad Medicine!

As a part of the healing program in this Congressional District, a Healing Arts Committee has been organized to elect a doctor to Congress who will be able to help you in your health problems. This doctor will be able to help you in your health problems. This doctor will be able to help you in your health problems.

**The Healing Arts Committee**

Each Congressional candidate has a duty to his constituents. The Healing Arts Committee is a group of doctors, dentists, pharmacists, nurses, and allied professionals who are organized to elect a doctor to Congress who will be able to help you in your health problems.

**Keep Politicians Out of Your Doctor's Office!**

We doctors and allied professions are not interested in politics. We are interested in your health. We are interested in your health. We are interested in your health.

The Healing Arts Committee of the 26th Congressional District  
 Joseph C. Anderson, M.D., Chairman

**REPUBLICAN COMMITTEE**

October 21, 1949

It is absolutely necessary that from this day on you report the following to your doctor:

1. Number of Doctor to Patient letters mailed by each REPUBLICAN doctor in each County.
2. Number of participants in each group, by County.
3. Report of other accomplishments such as Radio and Newspaper advertisements, pamphlets, etc.

It is imperative to have this information so that we can make overall plans for the balance of the campaign.

Please do not write long letters outlining future plans. The future is here and actual accomplishments must be reported and recorded. This is the only manner by which we can determine the positive value of our efforts in this campaign. Please send your report promptly, and only to individuals whom you may wish to help. A work sheet (back) and requirements of results, must be furnished.

Walter Blough

In Pennsylvania, doctors posted cards in their reception and consulting rooms asking their patients to vote for the "Healing Arts" candidate (left). Center: A newspaper display. Right: N. Y. Republican committee wants results.

healers failed to elect their candidate, John Foster Dulles, to the United States Senate. But Dulles carried 57 out of New York's 62 counties and lost only one county upstate, where the doctors' committees carried the most weight. "The margin of victory was the vote of the left-wing splinter party in New York City," says the Healing Arts report. In New York, the state medical society did not endorse the committee's efforts, as had been done in Pennsylvania—a circumstance which the report attributes to the New York society's "cosmopolitan nature, especially in New York City, where a large number of professional men were supporting Mr. Lehman, the Democratic candidate, for non-professional reasons."

Justifying the rough and tumble tactics that have sometimes been employed to run up these and other political scores, doctors like to assure one another that "you have to fight fire with fire." When Dr. Gilson Colby Engel of Philadelphia, as president of the state medical society, told Pennsylvania doctors that they had to get into politics in order to meet the threat of socialized medicine, a Pennsylvania newspaper, the *Bristol Courier*, noted that he was "hesitant and apologetic" about it. "Dr. Engel spoke of going into politics precisely as one might say, 'We've got to get our hands dirty to do this job,'" the *Courier* stated.

That's just it. The doctor's dilemma today emerges from the fact that poli-

tics is a dirty-hands business, and medicine has always been a clean-hands profession. Healing and healing don't go together. Actually, what Dr. Engel and others may be saying is that a good end justifies evil means—a doctrine that has been rejected by philosophers since the time of Hippocrates and is shunned by most doctors today in their personal and professional lives. However, only a few would acknowledge that evil, or even questionable, means have been employed. The "fire with fire" view, which is more embarrassed than ashamed or alarmed at the doctor's political behavior, is itself a minority. In the majority opinion, the Healing Arts report tells the whole story. The political gains were made, the report says, "because a single issue had been interpreted and fought on simple, clean-cut lines the electorate could understand!"

The simple, clean-cut lines are made clear in the report. "Healing Arts committees are composed of physicians, dentists, pharmacists, nurses and allied professional people," this says at the outset, leaving the precise identity of the allied professional people to be revealed in a later chapter. All these groups, it is explained, are organized on a city, county or state-wide basis. In the 26th Pennsylvania district they were organized in a hurry. "When the campaign opened in midsummer the principal issue was the Taft-Hartley Act—the issue on which the Democrats won the district in 1948," the report recalled. "The new Democratic

candidate, however, had given a 100 per cent endorsement to the Truman program, including socialized medicine. Republican Saylor was forthrightly on record against it. So on August 23, just three weeks before the election, we inaugurated the following program to make socialized medicine the principal issue of the election."

The program was a near miracle of lightning organization efficiency. In two days, doctors, dentists and druggists in each of the district's three counties had organized county meetings of their groups, received endorsements from state and county professional associations, distributed memoranda of instruction to workers, and raised several hundred dollars for advertising purposes. "Letters were written and supplied to doctors, dentists and druggists for mailing to their patients or customers, asking support for Mr. Saylor," it was reported. "Approximately 190,000 of these letters went into the mail. Another series of general meetings was held in each county within the next 10 days, at which auxiliaries of the Healing Arts group were organized to conduct both house-to-house and telephone calls in support of nonpolitical medicine and the Republican candidate. Approximately 120,000 such personal calls were made and proved most effective.

"A series of 12 newspaper advertisements, signed by the doctors and druggists, was scheduled in all daily papers in the three counties," the report continued. "Radio was used extensively.



## TOMY PATIENTS & FRIENDS

YOU HAVE THE RIGHT TO CHOOSE YOUR OWN

### DOCTOR, DENTIST, or NURSE

THERE IS LEGISLATION NOW IN WASHINGTON THAT MIGHT DEPRIVE YOU OF THE PRIVILEGE OF MAKING THAT CHOICE.

THIS LEGISLATION IS COMMONLY KNOWN AS

### "SOCIALIZED MEDICINE"

## JOHN FOSTER DULLES

Candidate for U. S. Senator, is against this measure. Robert Lehman is in favor of it!

### I URGE YOUR SUPPORT FOR SENATOR DULLES

I WOULD BE PLEASED TO DISCUSS THIS SUBJECT WITH YOU FURTHER, IF YOU DESIRE

(signed)

These posters were displayed in New York doctors' offices.

There were 256 spot announcements and six five-minute talks made by well known doctors over local stations. Doctors and dentists were supplied with a poster soliciting support from patients and friends. Nearly 500 of these cards were posted in consultation and reception rooms.

The posters were what made sensitive doctors gag. "To my patients and friends," these were addressed in 36 point type. "I am very interested in the election of John P. Saylor as congressman from our 26th district. Will you please do me a favor by going to the polls on September 13, 1949, and voting for John P. Saylor? If you need transportation on that day, please notify me at once." Doctors who regard these displays as deviations, if not corruptions, of the traditional patient-physician relationship must nevertheless acknowledge with the committee that the message is expressed in simple, clean-cut lines that the electorate can understand.

Many of the letters and advertisements produced during the campaign were fairly straightforward statements of opinion to which only hair-splitting socialists or moralists could object. "Freedom means more than dollars and cents," said the headline of one such ad. "We oppose socialized medicine because we wish to maintain the voluntary way, which allows men freedom of choice," the copy explained. "... We realize that enormous, burdensome taxes are needed to support such a socialistic program, and we feel

that the average worker's take-home pay is too small at present to support such extra taxation. We know that socialized medicine is not 'free,' and is a financial burden upon the very people it is to benefit . . . that for every benefit you receive from a socialistic government you must give up an equal amount of freedom."

But politics is a dirty-hands business, and not all the thousands of letters and advertisements the doctors signed and distributed were straightforward, or even true. One newspaper display, for example, proclaimed that socialized medicine was "a form of statism which has already put Great Britain in virtual bankruptcy"—a statement that has been used repeatedly in medical propaganda and is sincerely believed by thousands of doctors, but is just about as sensible as it would be to say that a patient with cancer is suffering from warts. As Winston Churchill explained in the recent general elections there, Britain's financial problems were brought on largely by losses of colonial wealth and world markets which left 50 million people living in an economy that will support only half that many. British socialized medicine is expensive and unwieldy and has brought heartbreaking burdens to the nation's doctors and hospitals, but it is not the cause of virtual bankruptcy, and in any case nothing even remotely resembling Britain's form of socialized medicine has been seriously proposed for the United States, by Democratic candidates for Congress or anybody

else. Fighting fire with fire does not make untruths into truths.

Nevertheless, when a Democratic district attorney in Cambria County, Pennsylvania, challenged the Healing Arts committee as not truly representative of the medical profession, the county medical society promptly called a special meeting, discussed the program fully and voted 51 to 1, by secret ballot, to support it. The district attorney's charge that doctors were being coerced into supporting Saylor was plainly unfounded. "In all, 260 doctors, 150 dentists, 110 druggists—plus many nurses, optometrists, chiropractors and other professional allies, including members of medical auxiliary societies—took active part in this intensive three-week campaign," the Healing Arts report said in summary. The ensuing vote eloquently demonstrated that it is possible "to play public opinion and make it light up like a pinball machine," as one reporter put it recently.

In the New York State senatorial election two months later, everybody else got into the act, but the state medical society stayed out. "This situation forced us to adopt the following strategy," the Healing Arts report noted sadly, describing the organization of an independent "Doctors for Dulles" committee under the chairmanship of Dr. Charles Gordon Heyd, a past president of the A.M.A. Dr. Heyd's committee immediately sent a letter to the state medical society's 26,500 members, asking them to be sure to register, find out which candidates were for and which against socialized medicine, and vote right. To help doctors and their patients and friends make up their minds about the candidates, the committee offered some highly organized, high-powered, political assistance.

"The campaign committee held two meetings with Governor Dewey and members of his official family," it was reported. "After explaining the Pennsylvania operation, the state of New York was divided into 26 districts, and 26 able men, present at the second meeting, were appointed as district captains to organize Healing Arts groups. Two general supervisors were also appointed—Mary Donlon in New York City and Robert Dineen upstate." Both supervisors are active in New York State Republican circles.

"Each district captain was supplied with an organization kit consisting of an outline of activities to be inaugu-



freedom of exercising my skill in serving you." The letter went on like that at some length and closed with the request, "as a service to yourself and to me and to America, that you, your family and your friends vote in this coming election"—for Dulles, who was described earlier in the same letter as "thoroughly opposed to socialized medicine and all other European 'isms.'" If a few squeamish doctors thought this sly suggestion (that a vote for Dulles was a vote against Communism) was unworthy of the Noble Art, the majority overlooked or ignored it. When sent out by chiropractors, all these form letters discreetly substituted the words "socialized health care" or "socialized healing" for "socialized medicine."

#### LEHMAN'S STATEMENT INTERPRETED

Many of the doctors who wrote letters were careful to point out that whereas Dulles was on record as unalterably opposed to the administration's proposals for a national health insurance program, his opponent's position was equivocal. Actually, Mr. Lehman had favored federal health insurance when he was Governor of New York in 1940 but made no clear-cut statement on the subject in the 1949 senatorial campaign. He did reply to inquiries on the subject by stating that he was opposed to socialized medicine but believed the "federal government must become a partner in providing medical care for the great majority of our people." This is the kind of statement that could mean almost anything, and some of the doctors made it mean whatever they wanted it to. "You have the right to choose your own doctor, dentist or nurse," said one of the "To My Patients" posters featured in the campaign. "There is legislation now in Washington that might deprive you of the privilege of making that choice. This legislation is commonly known as 'Socialized Medicine.' John Foster Dulles is against this measure. Herbert Lehman is in favor of it." A Healing Arts radio announcement made the assertion baldly: "The Democrat candidate in the U.S. senatorial campaign is for socialized medicine."

The spot radio announcements distributed by the Healing Arts committees for use by local stations provide a neat example of the medical profession using the patent medicine, or snake doctor, sales technic. "Do you like your doctor? Do you trust your

doctor? Certainly you do, particularly when you need him!" one announcement declared. "John Foster Dulles is supporting your doctor and you and the private, mutual relationship which exists between you and your doctor. . . . Keep the politicians out of your doctor's office. Vote for John Foster Dulles. . . . This is the Healing Arts committee, representing doctors and allied professions of \_\_\_\_\_ county."

"A vote for John Foster Dulles is a vote for your doctor and your faith in him," said another announcement. "A vote for the Democrat candidate may limit the doctor's ability to assist you when you most need it." "An invasion of outsiders has come into \_\_\_\_\_ county to give orders on how we should vote," still another radio spot began. "When we, the doctors of this county, explained that we stood for John Foster Dulles because he was against socialized medicine, just as we are, these outside exponents of socialized statism sought to terrorize us by threats." This reference to threatened violence was one of the oddest episodes of the campaign. It was never mentioned elsewhere in the report, and never explained.

Some idea of the frequency with which these and similar messages rode the New York airwaves during the weeks preceding the election may be gained from a time sheet of Station WGAT at Utica, N.Y., for Nov. 4, 1949. The Healing Arts "account," according to this record, was offered a 15 minute broadcast at noon on that date and spot announcement time at 12:59 p.m. and again at 3:29, 4:59, 5:59, 7:44, 8:29, 9:04 and 10:04. By the time they went to bed that night, the people of Utica must have been pretty sure what their doctors thought about John Foster Dulles and the private, mutual relationship which exists between doctors and their patients.

There were many variations on the major theme. In some counties, the working groups were known as "physicians and dentists committees to protect the welfare of the sick," instead of by the Healing Arts label. In others, hospital administrators and employees were included—on either the giving or receiving end of the letter-writing act. Some doctors organized local efforts through their hospital staffs instead of independently. Whatever form the organization followed, it was the district captain's job to keep the central committee informed of what

was going on. "Continuous liaison was maintained with all captains in New York City and upstate," the final report indicated. "Ideas were freely interchanged and all districts were kept alerted through bulletins like these." The bulletin referred to was reproduced on the letterhead of the New York Republican State Committee and carried the name of J. Russell Sprague, member of the Republican National Committee. "It is absolutely necessary that from this day on you report the following to this headquarters," the bulletin said. "(1) Number of Doctor to Patient letters mailed by each separate group in each county. (2) Number of participants in each group, by counties. (3) Report briefly other accomplishments such as radio and newspaper advertisements, pamphlets, etc. It is imperative to have this information so that we can make over-all plans for the balance of the campaign. Please do not write long stories outlining future plans. The future is here now and actual accomplishments must be registered and recorded. This is the only manner by which we can determine the possible value of our efforts in this campaign. Report on each county separately . . . and report every day regardless of results, until further notice."

#### 5000 DOCTORS ENLISTED

In New York City, the report explained, there was not time to organize a citywide Healing Arts group. Instead, "medical doctors only were called on a battery of 30 telephones from the Roosevelt Hotel and asked to participate in the campaign by mailing letters to patients and friends." Five thousand metropolitan doctors were enlisted by this method, a result the committee anticipated by thoughtfully providing the telephone interviewers with instructions on what to say.

"This is Mr. (interviewer's name)," the instructions said. "Dr. Charles Gordon Heyd (pronounced HAYD) asked me to call you. Dr. Heyd is chairman of a nonpartisan committee that is opposed to socialized medicine and for Senator Dulles, who is opposed to socialized medicine. Dr. Heyd would like very much to have you join this committee. Dr. Heyd has also prepared a letter for you to send to your patients, over your signature, outlining the case against socialized medicine. Dr. Heyd suggests that about a hundred of these

letters be sent you. Is that all right—Doctor?"

Obviously, it was all right with most of them. In addition to the 5000 doctors in New York City who took part in the campaign, the final report also listed as participants 5771 upstate doctors, 2981 dentists, 3515 nurses, 125 osteopaths, 1402 druggists, 506 optometrists, 3 chiropodists, 462 auxiliaries and 69 hospitals. In a section sportingly called "The Score," the report summarized what these groups accomplished. Statewide, doctor-to-patient letters totaled 1,279,123, doctor-to-patient telephone calls, 19,914. Other items were: osteopaths' letters, 65,000; chiropractors' letters, 600,000; postal cards (used instead of letters in Buffalo), 375,000; original M.D. letters, 26,500; original dentists' letters, 16,500; second M.D. letters, 32,000, and druggists' letters, 8700—a grand total of 2,422,737 simple, clean-cut messages the electorate could understand. "The entire cost of these operations to the Central Committee was \$3000 upstate and \$10,000 in New York City," the report stated, "—plus a small assessment for the New York office and telephone installations. All other costs were paid by local Healing Arts committees."

What was done in New York and Pennsylvania can be done elsewhere—with embellishments, the report concluded: "Our experiences in New York State showed that there are several classifications that are not fully de-

veloped but which would represent a tremendous influence in the election of any candidate where this socialized medicine campaign may be conducted. Those classifications or groups are as follows: nurses; hospitals, both state and private; medical and dental auxiliaries; insurance agencies and brokers and those who are engaged in selling Blue Cross and Blue Shield policies and other accident and health insurance policies—all of whom are opposed to the compulsory plan. These operations in Pennsylvania and New York set a pattern that can be profitably employed in future elections. They blueprint the method by which any issue may be 'sold' to the public through the assistance of informed and aroused groups of citizens."

During the year ahead, doctors and hospital people all over the country must decide whether or not they wish to take the place that is planned for them in this blueprint for political thought control. For most of them, the decision will be as easy as it was for the doctors of Pennsylvania and New York: "Socialized medicine is bad. Whatever opposes it is good. Count me in." Others, however, equally devoted to the end, have deep misgivings about the means. The late Frank Buchanan, Ohio Congressman who headed the House Committee on Lobbying Activities, stated the issue in an article written shortly before his death last summer. "We must recognize that groups and individuals seek

to influence government and education as a matter of constitutional rights," he said. "We cannot in any way abridge these rights without poisoning our system. I cannot imagine Congress operating without pressure groups. They raise issues, clarify them, and often provide the facts and points of view which are necessary to equitable legislation. The problem is to keep group activity honest with respect to its methods and open to public scrutiny."

With a matter of public and professional interest at stake, the doctor clearly has the right, if not the duty, to organize pressure groups. But because of the special position that he occupies in our society, which honors and trusts him above most others for his righteousness of purpose, he has a special obligation to keep the methods of his pressure groups honest and open to public scrutiny. The use of symbols and slogans as substitutes for thought and the kind of oversimplification that borders on misrepresentation are common pressure group tactics that the doctor must shun if he wants to hold his honored place in society. Whether his zeal to accomplish a desirable political aim can ever justify the use of these tactics, and the sacrifice of his righteousness, is a matter of opinion that the individual doctor must settle with his own conscience. Whatever the answer, we must never let the time come here when nobody dares to ask the question.

## BOTH SIDES "EMOTIONAL" IN HEALTH HASSLE: HAWLEY

SAN FRANCISCO.—Administration proposals for a national compulsory health insurance plan are both "praised and damned entirely on emotional grounds," Dr. Paul R. Hawley, director of the American College of Surgeons, declared here last month at the college's annual clinical congress.

"The problem has not yet been defined," Dr. Hawley said, speaking of the national health program. "Proponents of the plan confined their arguments almost exclusively to the field of catastrophic illness. Their examples of the burdens imposed by illness were limited almost entirely to the costs of chronic illness of long duration. Yet the plan itself did not meet this problem. It provided only for a limited period of hospital care."

"On the other hand, too much of the opposition to the plan ignored the

existence of some rather obvious problems in the field of medical care and offered no constructive suggestions as to their solution."

The proposal for a national compulsory health insurance scheme is dormant for the moment, Dr. Hawley warned, but "it would be entirely too optimistic to think that it is dead."

Voluntary insurance against the cost of medical and hospital care is seriously threatened today by abuses, Dr. Hawley said. Utilization of Blue Cross benefits has increased about 50 per cent in the last 15 years, during which time the cost of hospital operation has more than doubled. "This has forced the cost of Blue Cross to levels which threaten its expansion, and it must be greatly expanded if voluntary insurance is to succeed," he concluded.

In a report approved by the board

of regents of the college and released during the meeting here, surgeons were urged to consult more freely with family physicians about the patient's ability to pay for surgical operations. The regents' report also condemned surgical fee-splitting and rebates on medicines and appliances.

Dr. J. Roscoe Miller, president of Northwestern University and formerly dean of the university's medical school, told the congress that the medical profession no longer enjoys the universal affection and respect which the public gave the horse-and-buggy doctor of a generation ago. Dr. Miller said one reason for the loss of public esteem was the failure of some physicians to meet their responsibilities as citizens. To gain public confidence, he urged physicians to become more active in community life.





ST. PAUL'S HOSPITAL, DALLAS, TEX., AFTER THE FIRE.

Acme Photos.

## NO PANIC—NO CASUALTIES *proved the value*

### *of St. Paul's Hospital's program of fire safety*

**I**T WAS the Feast of St. Raphael, patron of the sick, October 24, Sister Alberta, administrator of the hospital, was awakened by the smell of smoke; she looked up at the ceiling as she rose and saw a small amber glow on the ceiling about 25 feet from where she stood. Quickly rousing the four other Sisters in the dormitory, she went to the nearest telephone and quietly told the operator that there was a fire in the attic over the Sisters' quarters and to telephone the fire department. The fire was discovered at 12:25 a.m., and the first alarm registered at fire department headquarters at 12:27.

The Night Sister on rounds first saw the fire at about the same time when going from the central hospital over to the Children's Hospital on her rounds. The telephone operator, Mary Jo Wilson, immediately upon notification of the fire went into the routine established on the "Standard Operating Procedure" posted in front of her. After calling the fire department she immediately sent out the hospital fire alarm code, "Emergency—Doctor Red" over the public address system four times. She notified the engineer and the nurses' homes. She then called the safety officer and purchasing agent. She kept the line open in the burning area. The instructions to remain calm,

and indeed all instructions, she followed in an admirable fashion.

Upon hearing the alarm two doctors on the resident staff went to the scene of the fire with extinguishers, but the fire had evidently reached such proportions by the time it had been discovered that the extinguishers were of no avail. (A fire brigade was in the process of being organized as part of our emergency program, but had not started functioning when the fire occurred.) Meanwhile all night employees, who had been instructed on what to do in case of fire, followed the established routine of moving patients from the floors beneath the burning roof and attic of our least fire-resistive building. The Sisters who had been immediately alerted were almost at once at their respective duty stations.

As soon as most of the patients had been moved from the main building to the annex, cut off from the main unit by a fire wall and smoke doors, the fire chief made the decision to evacuate the entire building, since the fire had rapidly spread toward the attic section of the annex building to which all patients from the main

building had first been moved. The helpless had been moved either by bed, stretcher or, in some cases, mattress into a safe area on the same floor, and at the same time the wheelchair patients had been moved and the ambulatory patients had walked.

Helpless patients were moved down on the freight elevator in the annex. All had been provided with suitable covering; the weather had turned cold that afternoon. The babies in the nursery, located on the fourth floor underneath the burning fifth floor, were the immediate object of rescue and it is reckoned that they were safely outside the building on the way to the emergency nursery being set up in the nurses' home within five minutes after the alarm was given. Some had been taken by their mothers, some by nurses on duty. One patient was in the delivery room, located immediately under the fifth floor Sisters' dormitory, when the fire broke out. She was delivered shortly after 1 a.m. in the nurses' home. Within less than 20 minutes 254 patients had been completely evacuated from the hospital, without the loss of a single life, and, at last report, without serious impairment of any patient's recovery.

The great majority of the patients had been evacuated through the Hall Street entrance at the east end of the

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Personnel Director and Safety Officer  
St. Paul's Hospital  
Dallas, Tex.

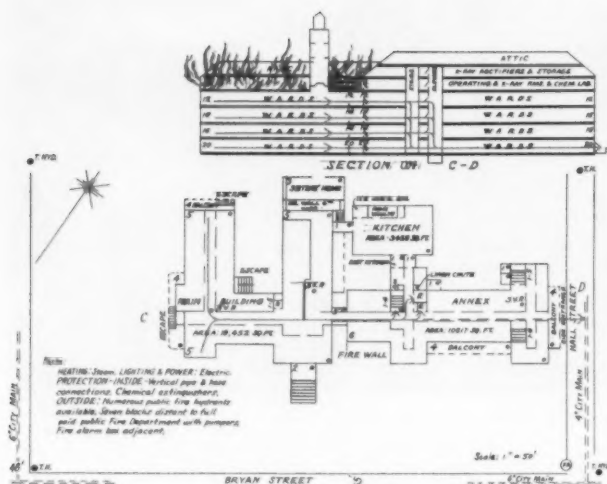


Diagram showing routes taken by patients from main building.

building; a few had been evacuated through the front entrance to the building, since for some patients this had been a safer and more convenient exit. Almost immediately the patients started coming out the east entrance, the fleet of ambulances, taxicabs and some buses alerted by the police department were on hand to begin transferring patients to other hospitals in the vicinity, or to their homes, if they

requested it. One man was bumped along Hall Street south to Baylor Hospital about five blocks in a straight-back chair propelled by two worthy stalwarts, evidently no worse for wear afterwards!

Within an hour after the fire started most patients had been safely located because of the emergency transportation system devised by the police and because of the wholehearted hospital-

ity of the other local hospitals. For the patients who needed hospital care, there were, miraculously, enough beds in the various hospitals. At about 4 a.m., when the fire chief decided that patients could be moved back into the annex, we had two patients back in bed on the first floor of the annex. The fire had been brought under control about 3:30 a.m.

By afternoon of the day of the fire all 102 beds in the annex were filled with evacuees. St. Paul's was back in operation. What had been lost was the central service department, two of the three Sisters' dormitories, the "glucose rooms," and the surgical linen room. The fire had been arrested just short of the fire wall that blocked the fifth floor of the main building off from the fifth floor of the annex which housed laboratory, x-ray and surgery. The main building elevator had also been wrecked, by water covering the motor at the bottom of the pit, and by fire in the penthouse structure housing the elevator support.

Just five weeks before the fire occurred, St. Paul's put out a revision of the administrative policy book. In it were two sections on fire safety, one entitled "Fire" and one entitled "Fire Prevention." The latter dealt with general and particular methods of preventing fires and laid down the general principles of fire prevention. The section entitled "Fire" gave instructions about extinguishers, the fire alarm code, the avoidance of panic and the general theory of patient movement and evacuation.

The administrative policy book has a special place in the employee's life at St. Paul's, inasmuch as the employee must be thoroughly acquainted with our policies, and it is to his advantage to be. Special emphasis was placed on the fire policy by the safety officer's periodically going from floor to floor quizzing, especially key personnel, on the various contents of that policy. There had been no fire drills before the fire; the only drilling done was mental. That will probably remain the policy of this hospital because it is felt that a full-scale drill, simulating fire conditions to a certain degree, would not be conducive to many patients' welfare.

There is a possibility that we may institute a drill which simply calls employees to their duty stations briefly, and simply acts as a reminder of the ever present need of vigilance. The patient should know nothing of this



An emergency crew transfers seriously ill patients from the annex.



## INSTRUCTIONS FOR EVACUATION

Every employee should well understand the theory behind the well considered plan for removal of patients from an unsafe area to a safe area during a fire. Evacuation of patients from an imperiled area is an operation fraught with many serious possibilities. Evacuating patients in a general hospital, by use of the stairways and fire escapes, would involve such difficulties that every effort should be made by hospital personnel beforehand to protect against all fire hazards to the point where evacuation will rarely if ever be necessary. Hospital personnel should not think in terms of complete evacuation when such may not be necessary. Think first in terms of moving patients, especially the helpless, laterally or horizontally, that is to say from an unsafe area to a safe area on the same floor, beyond the fire and smoke barrier doors between Main and Annex. This is the procedure universally recommended by all fire underwriters, fire marshals, and safety engineers.

Remember that the number of patients being moved by bed must be held to a minimum in order that congestion may be avoided in that area of safety to which all patients are being transferred.

## INSTRUCTIONS TO SWITCHBOARD OPERATORS

BE CALM BE REASSURING DON'T SHOUT "FIRE"  
FEAR AND PANIC CAN DO AS MUCH DAMAGE AS FIRE  
PROCEDURE FOR OPERATORS IN CASE OF FIRE:

1. Notify Fire Department RI 6543.
2. Announce over P.A. System four (4) times in a moderate, clear voice:  
"EMERGENCY—DOCTOR RED" followed by location of fire.
3. Notify: Chief engineer (in charge of fire brigade)  
Administrator  
Nurses' homes  
Safety officer  
Purchasing agent
4. If switchboard current is affected, don't forget to try public telephone booth near by or an outside wire. In booth ask central operator to keep line open for you.
5. KEEP LINE OPEN IN DEPARTMENT WHERE FIRE IS LOCATED.
6. Remain at switchboard to give and receive instructions. Speak in moderate tone of voice. You are the heart of the entire communications system of the hospital.  
*Be Prepared.*
7. Guard list of patients in hospital.
8. Switchboard will be rallying point for all clerical employees of the hospital for message running.
9. ALL CLEAR SIGNAL:  
"DOCTOR RED—EMERGENCY ENDED" to be given on order of the administrator.

drill if possible. This is a well considered policy which should be given some thought by all general hospital administrators, even though they do not necessarily agree with it. If your staff is made intimately acquainted with your policies and fire procedure, it will act the way it should during an actual fire.

It should be mentioned here that apart from our actual written policies and procedures the administration, both at the central headquarters of the Sisters and locally, was extremely "fire-conscious," and that this consciousness had been instilled in key personnel of the hospital. To illustrate: At the time the policy book was being revised and discussed by key personnel in the hospital, one of the nursing arts instructors in the school reported to the safety officer one morning that she "had been fighting fires all night" and had had the constant din of "Emergency—Doctor Red" in her ears throughout the night, let the psychoanalysts fall where they may.

To illustrate the administration's attitude toward fire prevention at St. Paul's, in 1948, before the great surge of truly impressive fire inspections throughout the country, an open staircase had been removed. This staircase had led directly up into the Sisters' dormitory where the fire raged October 24!

Two months before the fire occurred, the central staircase, an open one, in the main building had been closed off upon the recommendation

of all fire inspectors and underwriters and was in the process of being reconstructed into additional rooms and an enclosed staircase. Plans were being made to have the few recommendations on the annex, built in 1916 (a more fire-resistive building than the Main and having three enclosed stairs), carried out. The new construction, a building of 150 beds soon to open, and attached north and south to the annex at the east end of the building, is as completely fire-resistive as it is possible for modern construction to be.

### ALL AGENCIES COOPERATED

Of course, it cannot be sufficiently emphasized that the various fire prevention organizations throughout the country and those companies carrying insurance and compensation on the hospital were most valuable in helping us to be fire-conscious. We have had, as all hospitals have, frequent inspections, and valuable advice has been given by all these organizations, all of which recommendations the administration was aiming to carry out as soon as practicable. Every hospital administrator knows what practicability means in this matter; everyone has budgets to contend with. All the organizations interested in fire prevention with which we have had dealings have been thoroughly cognizant of this problem and sympathetic to the predicament hospitals in general face. We feel that we have gone out of our way to comply as soon as possible with their recommendations, because of

their obvious importance. Certainly it has paid off in insurance rates, in actual building safety and fire resistance, and most important, in the saving of human lives.

Before going any further, the sources from which we took our ideas for fire procedures should be mentioned. Three pamphlets were mainly responsible for the ideas and regulations compiled. They are the operating procedures set up by the Omaha fire department in cooperation with the local hospitals, the "Standard Operating Procedure" of the Good Samaritan Hospital in Watertown, N.Y., and the pamphlet "Hospital Fire Safety" published by the National Fire Protection Association (1949). The "Fire" pamphlet published by Northwestern Hospital in Minneapolis was also valuable.

The best and most applicable part of the procedures of the first two were combined for the production of our standard operation procedure. The most valuable aspect of the N.F.P.A. pamphlet was the fact that many other hospital fires were discussed in detail and this gave some vicarious experience to the safety officer. The N.F.P.A. also was valuable to us in giving us general theory of evacuation (the other pamphlets were helpful in this respect also) and a ready reference to building codes, so important to fire prevention and safety. All hospitals are most fortunate now in having at their disposal the American Hospital Association's new pamphlet on fire emergency pro-

grams, which combines the sources mentioned with added clear and original thought and suggestion from the editors of this brochure.

As is obviously indicated, a compilation from these sources had to be applied to local conditions, an activity which, if done properly, takes a good deal of time, study and revision as the S.O.P. plan evolves. It takes time to tie all the local loose ends in to the picture, especially if the physical setup of the building one is working with is not every way in line with building codes and recommendations. In most hospitals, this process is a continuous one, each change in the physical set-up modifying the S.O.P. already established.

Question: Until the public address system has been extended to all non-nursing departments, how will the fire alarm code be transmitted to these particular nonnursing departments?

Question: Which is the best method of publishing the S.O.P.'s on the various divisions? Will they be in the form of a booklet or will there be a framed set of instructions on the wall? If instructions are to be displayed on the wall, where will the best position for them be since the public should not have access to them?

Question: What do we do in lieu of emergency lighting facilities in the surgery should surgery be in progress when a fire breaks out and electrical lines are put out of commission? The details to pay attention to are seemingly endless.

### THREE POINTS STRESSED

Since the aforementioned sources of information are readily available to all as they were to St. Paul's it would be pointless to present all our procedure here, especially since space is limited. It may be advisable, however, to discuss three items that may be of use to readers, and which were of particular value to the hospital at the time of the fire, especially the first and second which were all that were actually needed in the recent fire.

The first is the policy on "fire," the second is the telephone operator's procedure, and the third is the S.O.P. for the nursing divisions on the four floors of the central hospital; in this procedure the building referred to as the Dallas Building is the new construction, two wings on Hall Street. In the first item the fire alarm code has already been changed because of the publicity given it after the fire.

For the type of fire that we had the first two items mentioned are all that were absolutely necessary inasmuch as there were no patients immediately involved in any burning section and simple directions for hospital personnel could have sufficed. Employees knew the fire alarm code and went into immediate action when the code was given out. They did not alarm patients; they avoided panic. No one went around shouting "fire!" So far as we can tell, every patient who was not awake was roused gently and told quietly to either get up quietly and walk in the direction that the charge nurse would indicate or was immediately moved by wheel chair, bed or stretcher if helpless or semihelpless. One nurse told an ambulatory patient when she woke him up to come quietly as there was a fire and he could see it better down the hall!

### DID NOT USE FIRE ESCAPES

Sisters were at their duty stations almost as soon as the patients were awakened, and volunteers appeared on the scene from the street as if by magic. One of the surest indications that the patient-movement part of the plan worked and that there was no panic whatsoever was that there was no single attempt to leave the main building by any one of the three immediately available fire escapes in the main section all clearly and brightly marked by the red exit lights.

Patient movement by the hospital staff followed to the letter the theory indicated in the "Fire" Policy (see diagram). On each floor, the patients were moved into the annex past the fire wall and smoke barrier doors. At about the same time this had been accomplished, the fire chief ordered the complete evacuation of the hospital.

Steady heads on every floor then saw to it that patients from the main building on the upper floors of the annex were evacuated before those on the third and second floors. Ambulatory patients in the annex used the enclosed stair at the east or Hall Street end of the building. The diagram shows routes taken by patients in the main building, which patients we are mostly concerned with here since they were the only patients immediately in danger on the upper floors from the fire.

The telephone operators' procedure was obviously most important in that

every step involved had to be carried through if all the other procedures were to work the way they were meant to. The calm and collected demeanor of the night operator cannot be praised enough.

It would be folly to suggest that all that is needed for a fire emergency program is a central operator who knows what to do, plus the general theory of patient movement, a fire alarm code and the knowledge instilled into personnel that panic is to be avoided at all costs. But the hospital that has at least this much has gone a long way in the right direction, and it is a first step that all can take until more can be worked out in the fire emergency program. We had done so already (and in addition we had instruction plaques for each fire extinguisher on order) but one of the things to be learned from the fire at St. Paul's, given the type of fire it was and in the location it was, is that a basic and comparatively simple plan will work wonders also. But let it never be forgotten that even the simple program takes real planning and constant action for it to be effective.

### THE FIRE CHIEF MUST DECIDE

One of the most valuable comments that can be made upon the activities of that night of the fire involves the order for complete evacuation of the building. When the Fire Chief arrived he quickly but thoroughly studied the situation and made a decision. Evacuate the entire building! Our whole program, however, had not been aimed at complete evacuation of the hospital except under the most unusual of fire emergencies, and then the staff would have had to use its common sense after it had done everything the procedures called for.

Our program was based on the idea that if a fire broke out in the main building it would be some time before it could spread past the fire wall into the patient area of the annex and vice versa, thus affording a good time lapse for any complete evacuation to be effected in an orderly and safe fashion. Furthermore, if there are too many instructions for the employees, they may be more confused than collected at the time of an emergency.

It is gratifying that no patients suffered severely as a result of the evacuation, and it is also quite possible that had the patients remained in the an-

(Continued on Page 140)

# Social Medicine

*Hospital and home care combine*

## TO CLOSE THE GAP *between*

*the practice of medicine and the social sciences*

THE development of the biological sciences, of which medical sociology is the finest and most recent flower, has placed in our hands a number of the instruments of progress in the area of medical care. We understand the origins of human woe these days better than ever in the tortured history of mankind, and we need not be helpless about them. Antibiosis is now understood alongside of symbiosis, for it is one thing to neutralize or destroy your enemy, and another to convert him to your friendly purpose.

### HAS IDENTIFIED FOES

Modern medicine has not only succeeded in identifying most of our pathological foes, it has, in fact, elaborated the means of dealing with them. Any one of us can identify outstanding personalities in modern history whose maniacal tendencies were obvious long before they embarked on their destructive work. Many of the fateful decisions of history have been made by men who were more or less imperfect and the extent to which they succeeded, and embroiled the rest of mankind, who perforce accepted their leadership, is the measure of absent or imperfect therapeutics, so far as the social physician is concerned. Only a man healthy in mind, if not in body, can be a constructive statesman. It is for this reason that we place the greatest emphasis on the potentialities of social medicine, in its broadest aspects, in guiding the destinies of the human family.

After millenniums of seeking, we have been ushered into an era of history when we have the means with which to close the gap between the social sciences and the practice of preventive

### E. M. BLUESTONE, M.D.

Consultant  
Montefiore Hospital  
New York City

and curative medicine. Because we have faced our bacteriological enemies boldly, intelligently and tenaciously, we have reaped the reward of longer life. The breath-taking tempo of latter-day medical invention and discovery has, however, kept us ahead of the social sciences. As a result, an increase of years may prolong a calamitous existence if it is the gift of the mechanical sciences only, and not of the social sciences. It is this blessing of a full quota of years, often mixed with the curse of prolonged illness, which compels our attention more than ever. Life must be made more endurable, if not more comfortable, and this can only be done when environmental influences are taken into full consideration in diagnosis and therapy—in social etiology and in social pathology.

The right of the physician to prescribe involves the obligation on his part to use every available ingredient, in the prescription, which is compatible and therapeutic. Moreover—and this seems unfair in our present economic arrangements with him in most of the civilized world—this right to prescribe involves the obligation to follow through, regardless of the ability of the patient to pay a fee for the service. The physician is not limited by a rigid chemical formula, or mechanical operation, which is expected to be good next time only because it was good the time before. He must, in short, have the closest familiarity with the environmental origins of disease and have at his disposal, for ready use, every preventive and therapeutic modality to deal with it. In such a life-giving ac-

tivity he cannot work alone, unaided by sound community planning.

It is no exaggeration to say that the practice of social medicine is a way of life, for it embodies in its doctrines everything that can contribute to the highest good of mankind. Until the physician is recognized, encouraged and supported, in his essential rôle as social worker with a highly specialized mission in life, we shall continue to have only the limited benefits of his ministrations in moments of "acuteness," consisting of the practical application of drugs and surgery—purely mechanical methods which are, in many instances, palliative only, for the relief of subjective symptoms and objective signs.

### MUCH MORE TO BE LEARNED

We have, in these thoughts, the basis of a sound program of medical care. As we view the patient stereoscopically, and as the social and medical components coalesce before our eager eyes, we see a comprehensive kind of medical care which encompasses far more than the hospital in establishing the ultimate laboratory of the medical scientist. With overemphasis, and some imbalance, we have erected great but rigid edifices, and dedicated them to the art of Aesculapius. Our preoccupation with the hospital bed, and the high concentration of medical talent within its walls, will, however, be seen to have been somewhat shortsighted, in the knowledge that there is far more to be learned, to be understood, to be prevented, and to be dealt with, outside of the hospital walls. The best lessons in medical practice are not necessarily learned at the point in time and space when a man faces a court of last resort, as he often does in a hospital bed. He might have been spared the aggravat-

Condensed from the principal address delivered before the seventh International Hospital Congress, Brussels, July 1951.

ing experience by timely interest, and perhaps subsidy of one kind or another. The doctor's office, the ambulatory, the health center, the school-room, the home, as well as the hospital, each have a contribution to make to the practice of good medical care, and the earlier the better. Modern medical care, and devotion to the best in the scientific practice of medicine, require a completeness, a comprehensiveness and a continuity which cannot be achieved by segmenting the individual, or by transferring him to other hands in discouraging moments when medical interest lags. The practice of medicine, to be scientific, must not be subjected to the rules of the market place for, if it is, the fee, especially when it cannot be paid, or the passing whim of a patient who decides to swap horses in midstream, will determine spuriously the quality of medical care and medical research.

### THREE TYPES OF PEOPLE

The practice of social medicine deals with three types of people: (1) *the near-sick*, with whom preventive medicine has its greatest opportunity; (2) *the sick*, with whom curative medicine has its greatest opportunity, and (3) *the recently-sick*, who require the kind of facilities which will enable them to clinch their cure, prevent relapses, and return as useful members of their environment. Rehabilitation is the quintessence of social medicine at the end, just as preventive medicine is the quintessence of social medicine at the beginning. Modern medical practice cannot be content with a cure, which means, in many cases, only the relief of urgent signs and symptoms. It must project this medical concept into the social field of rehabilitation, which is only another way of saying that the individual must be seen and dealt with as part of the world in which he moves and from which he derives sustenance. And the effort must be as stubborn as the illness with which it must cope.

We are, in fact, at a crossroads in the field of medical practice these days and must decide which way we desire to go. What do we want of the practice of medicine? Shall we continue to content ourselves with the relief of pain, fever, hemorrhage, unconsciousness, or shock, under the restraints of limited directives by patients who must be guided by the contents of their purses, or shall we dig deeper over a wider area for ways and means of acquiring a more endurable form of cure

in cases where illness cannot be prevented. At what point between "acute" and "chronic" disease is a physician privileged to turn away from a patient, while aggravating matters by failing to refer him to hands which may be more capable in certain baffling situations? What happens when acuteness wears off and is succeeded by lingering discomfort, unrelieved anxiety, and downright suffering, which complicate the factor of chronicity?

That this may involve us, as a community, in financial obligations which may prove unbearable is one way of examining the subject, but it is a narrow and shortsighted way, because the returns from preventive and rehabilitative effort are far more significant than the savings which result from negativism. A physician subsidized for the care of the poor is more valuable and more productive than the one who is compelled to offer his services without charge. Here is an investment of public and philanthropic funds which is sure of a handsome return. One cannot read the latest report of the Office of Vocational Rehabilitation in Washington, for example, without pondering the statement that every successfully rehabilitated civilian returned to the federal government 10 times as much in income taxes as the sum of the investment in his rehabilitation.

The simon-pure administrative technician, working within the executive offices of the hospital and giving no thought to the world beyond its walls, is being driven out of his shell, like the physician, by the sheer force of social and economic circumstances. In control of the best medical facility known to modern man, namely, the general hospital, the administrator and the governing authorities of such hospitals are beginning to understand the menace to the public health of an exclusive and one-sided policy of service.

If the modern hospital is the best medical facility at our command, why are its services limited to the patients within its walls, whether they actually belong in these beds or not? Is it for the public good to encourage the sick to occupy beds within hospital walls when they can do as well, if not better, at home under hospital auspices? Where there is no choice and where, for example, the sick man requires major surgery which is best done in the general hospital, the hospital bed is naturally prized, but here too the impersonal characteristics which no hospital can altogether avoid, in the me-

chanical routines which control its activities for relatively short periods of time, must be taken into consideration and dealt with. But, where there is a choice, and the patient is referred to the hospital for any other reason than scientific necessity as, for example, when his relative poverty deprives him of the opportunity to secure in his own home the diagnostic and therapeutic services which he needs for his cure and cannot otherwise obtain, we should hesitate long before sending him there. No one has ever suffered from nostalgia for a hospital bed. Except through force majeure, as indicated above, the patient should remain with his family, under the protecting medical wing of the hospital if necessary, and not be robbed during illness of a major ingredient in the prescription for his cure, namely, individualization of care. The patient whom the hospital has taken under its protecting wing in his own home has the therapeutic illusion that the hospital exists for him alone. The best of all hospitals will be the one that has found the way to maintain a personal kind of protective interest in every patient from beginning to end. Sickness can be a humiliating experience, but there is one part of the prescription which surpasses all others and this is summed up in one word—kindness.

### ONE-FOURTH THE COST

We have learned, from successful experiment, that extramural care radiating from the hospital into the patient's own home, subsidized in his own environment if necessary, is approximately one-fourth as costly, on a comparable basis, as hospital care. The bed, and most of the service, including freedom from structural and administrative overhead costs, are a free gift to the hospital when the patient can remain in his own home. If, therefore, the hospital will bring highly expert care on a mobile basis to the patient and his doctor at home, it will be done at a considerable saving to the community. In this way we will be able to do away with artificial distinctions made between "acute" and "chronic" patients by physicians, and by hospital authorities, on the score of duration of illness. We can determine the exact need of each patient and then locate him, intramurally or extramurally, in accordance with the urgency of his condition only and his need for one kind of service or the other. If he is homeless, or home-poor, we must find



a substitute for his home, under hospital supervision, never forgetting that while there is a substitute for the home there is no substitute for the hospital.

One must bear in mind that hospitals are more than first-aid stations, and that they were not created for the care of curable patients only. They are scientific establishments which employ the best in modern facilities, while teaching and adding to our knowledge of disease, and as such must deal with every challenging medical situation in the community no matter how long drawn out, how tenacious, or how complicated. The more stubborn the problem the greater the demand for the continued interest of the scientist. Acuteness of disease commands a prompt response and, by its very nature, lasts a short period of time. Chronicity of disease calls for sustained interest which never ceases to seek the remedy till death takes over. In acute disease the response is automatic, if only because of the agonized cry for help. In chronic disease, now referred to more kindly and helpfully as "prolonged illness," the response must continue even though the appeal for help is subdued by a dulling of the symptoms.

We have here a pattern of care which provides for the sick in accordance with their needs and places them in relation to their urgency. It depends on an integrated intramural and extramural (home care) hospital service and calculates the distance between a sick man and the hospital bed in inverse proportion to his urgency. The greater the urgency the less the distance between the patient and the central hub of the hospital.

#### REPRESENTED BY WHEEL

Schematically, this pattern of medical care can be represented by a wheel which is surrounded by a series of concentric circles. The hub of the wheel is the central core of the general hospital. Here are located all of the scientific (diagnostic and therapeutic) facilities which are required to deal with difficult clinical problems. The spokes of the wheel, or the segments of the circle, represent the clinical activities of the hospital, such as the outpatient department (for patients who do not require hospital beds and can safely and comfortably report for medical care in this way) the private section, the ward section, the convalescent section, the tuberculosis section, the section for mental illness, the section

for communicable disease, the doctors' office building, the group practice unit (such as the diagnostic clinic) and any other similar activity. The rim of the wheel is the circumference of the hospital—the walls which limit its activities. The concentric circles which surround the wheel reach out beyond the hospital walls into the patient's home. The patient, young or old, rich or poor, acute or chronic, can thus be located in accordance with his need, from point zero at the center of the hub, to the most distant point where his home may be located, always getting the best medical care by the joint efforts of his physician, whether he be paid by the community or the patient, and the hospital, when and where he needs it. When the day comes that admitting officers in hospitals will cease to judge applicants solely by their prognosis, the degree of their fascination for this or that member of the attending medical staff, the duration of their illness, their age or their social status, and apply the criterion of actual need for a hospital bed, we shall see a pattern of medical care which fulfills the ideals of the most humane physician.

#### POVERTY IS GREAT PROBLEM

The complication of economic necessity which has thus far been one of the controlling factors in medical care generally, and in the hospitalization of the poor patient in particular, can be dealt with by the community on a far less expensive scale than the indiscriminate assignment of a hospital bed. At this point in our planning we are reminded that prolonged illness and poverty have a strong attraction for each other. Medical care is expensive enough for the acutely sick patient; for the patient with prolonged illness it can be catastrophic and extend moreover for a fearsome period of time. The planner must therefore deal with this problem by breaking somewhere the vicious circle in which prolonged illness and poverty are caught. Otherwise, the poor patient is deprived of both kinds of currency, financial and medical, which he needs so desperately. The solution suggests itself by a process of financial subsidy rather than by the assignment of patients in such a way that medical care becomes a matter of all or nothing. The sick man must be subsidized financially, medically and psychologically when he cannot take care of himself either by insurance or on a fee-for-service basis. To the extent that hospital care is the most expensive

kind of medical care, from any angle, we would do well to consider a redistribution of the patient load on more logical lines. If you plot the patient's need for subsidy along a horizontal line beginning with zero and extending out to 100 per cent, and then plot the actual subsidy on a vertical line which is at right angles to it, so that the exact subsidy will correspond to the exact need, the resulting "curve" from point zero will be a straight diagonal line bisecting the right angle and indicating the extent of the problem for the community, provided that the number in each category can be ascertained. Some require full subsidy; others require a varying degree of financial help to see them through a difficult period.

#### CAN SEE THE PROBLEM THROUGH

At the bottom of the approach of social medicine to this pattern of medical care is the significant key factor of individualization. Any other method is expensive, wasteful of hospital beds, careless of the sensitivity of the patient, exclusive, and antisocial in the sense that the best things in medical life are established but available only to a relatively few, and then only in acute situations.

For the student of prolonged illness, whether he is a sociologist, physician or both, we have here a pattern of medical care which, properly applied, automatically solves most of the lesser problems of medical care of our time. Moreover, it has the great merit of giving to the scientist an opportunity to see his problem through from beginning to end. The sick man need no longer be a stranger to the hospital physician for a relatively short period of time or, for that matter, to his own doctor, depending in large measure on his financial ability to pay fees and his willingness to continue with the same doctor. He is under observation from the beginning (if his illness was not preventable) till the end. Under hospital auspices intramurally and extramurally, the group practice of medicine prevails throughout, with every type of mobile facility (personnel plus equipment) available to the extramural patient that is now available to the intramural patient. Opportunities for scientific research are thus enhanced and the opportunities for medical invention and discovery, extending out into the field of social medicine, are increased and made more effective for longer periods of time. Medical research requires completeness, compre-

hensiveness and continuity of care for its development and nothing less can achieve as much.

From the teaching point of view there are far more lessons to be learned by the student under such a combined

intramural and extramural program than in any other way and not the least of the advantages is the encouragement to the young student to retain and perpetuate, rather than discard, his most precious inheritance from the Hip-

ocratic tradition. Under any other plan of medical care the young physician finds himself sooner or later influenced adversely by economic necessity and the result is a compromise with his ideals. One must remember here that the practitioner, under this plan, is forever exposed to hospital medicine from which he draws scientific help at strategic times and has at last the opportunity, which he has coveted for so long, to study each case according to its requirements. For the social worker the boon of medical cooperativeness and understanding will in itself be a blessing for, as matters now stand, this worker must seek help for the patient where the doctor has lost interest.

The experimental work with this program was first done in Montefiore Hospital for Chronic Diseases in New York City, which is the only voluntary general hospital of its kind, of high scientific grade, in America, and an excellent laboratory for the study of social medicine. This demonstration project, microcosmic as all such experiments are, was indeed so successful that it was eventually adapted to the group practice unit which serves an insured section of the population, and also to the family health maintenance project which emphasizes (1) prevention for a group which is already insured for curative care, and (2) the family, and not alone the individual. The net result was a radical change in hospital organization by which a new division was added to the existing clinical and laboratory divisions, namely, a division of social medicine. This division is presided over by a full-time physician whose duties run parallel to those of his colleagues on the other divisions of the hospital. The new division of social medicine has absorbed the social service department and now has the primary function of (a) administering the various projects under its care, (b) cooperating with the clinical and laboratory divisions, (c) teaching the precepts of social medicine, and (d) exploiting the possibilities of research in this field. Many convincing lessons have been learned and some of these have provided the basis for this presentation.

Over a period of four and a half years we have been deeply impressed by the humanity of this new type of organization but, in addition, it has the great merit of relative inexpensiveness and of utter simplicity of execution.

## Action to Relieve the Nursing Shortage

**S**UGGESTIONS for relieving the critical shortage of nurses in New York State are embodied in an article entitled "Recommendations for Action to Relieve the Nursing Shortage" by the committee on public health relations of the New York Academy of Medicine appearing in the September 1951 issue of the academy *Bulletin*.

It is the opinion, the authors state, of the New York Academy of Medicine that steps should be initiated by the New York State Department of Education, with the aid of local bodies, to plan a legislative and administrative program for early action. The following points were submitted for consideration in conjunction with such a program.

1. The age at which young women may enter upon active nurse practice should by legislative act be reduced from 20 to 18.

2. Nurses not licensed in this state should be permitted by legislative act to serve on the nursing staffs of hospitals under supervision in the same manner as interns are now permitted to serve before they are licensed to practice.

3. The training of practical nurses should be continued, and any effort to abolish such training should be vigorously opposed. The schools for practical nursing should be developed to fulfill the need for competent people to take care of patients with non-acute conditions and to provide for the care of those with long drawn out maladies or in the convalescent stage of illness. The practical nurse has established a secure place for herself in the care of the sick, both in their homes and in the hospitals.

4. The academy stands opposed to the proposal that all candidates for nurse training should be high school graduates. Such a requirement would automatically eliminate some of the most valuable sources of practical nurse power, young or middle-aged women with a talent for nursing, who have not finished high school. Many ca-

pable women, who for some reason have not completed an academic high school course, are well able, as practical nurses, to give simple care to the sick under the supervision of a physician or a graduate nurse. This reservoir of potential nursing service must not be ignored—the country needs all the nurses that can be mustered.

5. Changes in procedure are recommended to permit that all necessary instruction in nursing be completed within the statutory two years and that the third year be devoted, as it were, to an internship on a salary basis. This would make available to hospitals a great deal of the time of the third year, which now includes class work.

6. All training schools should be alerted to the possibility that a two-year course may supersede the present course and should be requested to make the necessary adjustments in their curriculums.

7. Every effort should be made to stimulate nurse recruitment. The proposed reduction of the course from three to two years, with the opportunity for those who so desire to obtain specialized instruction in clinical or administrative phases of nursing at educational institutions, will appeal to young women who are responding to nursing as a vocation, first, because of the opportunity it offers for service, and, second, because of the educational status it affords for those who elect a degree in nursing. Every resource for adequate training of nurses should be availed of. Joint nurse-training programs for hospitals of a given region, if they desire to participate, should be encouraged.

The committee closed the article with a plea for action. The time for leisurely discussion is past. Those responsible for administrative changes in nursing education should make necessary preparations to act without delay in this emergency.—MALCOLM SMITH, *administrator, Richmond Memorial Hospital, Staten Island, N. Y.*





NORTH SHORE HOSPITAL, MANHASSET, LONG ISLAND, N. Y.

## THE MODERN HOSPITAL OF THE MONTH

# Expansion Without Dislocation

*is the goal of North Shore Hospital*

THE drawings on pages 66 to 69 represent the first stage of construction of the North Shore Hospital, Manhasset, Long Island, N.Y., which provides 182 beds, but by doubling the nursing units to two per floor and by making slight additions to the operating, delivery and other departments, the capacity could be increased to about 364 beds. All of the provisions that will be necessary to the doubled bed capacity have been fully anticipated in the present plans so that the future expansion could take place without the destruction of values created in the first phase and without dislocation of functions or discomforting the patients. In fact, the form of the present plan was decided upon pursuant to an evaluation of immediate investment *versus* future cost, functional disruption and patient discomfort.

This evaluation showed that a temporary saving of about \$70,000 could be made if the first stage of the hospital were planned with two nursing units per floor, implying a two-story nursing pavilion. This would have involved carrying either maternity or surgical patients via elevators to the delivery room or the operating department, depending on which of these was placed on the third floor of the service wing. It also would have meant that during the implied future vertical expansion from

two to four stories the patients on the second floor would have to endure overhead noises and temporary shut-offs of services.

The deliberate commitment to make an outlay now in favor of a four-story-one-nursing-unit-per-floor scheme has been referred to as "temporary" because it merely constitutes an advance investment toward the ultimate four-story-two-nursing-units-per-floor hospital. It is implicit, however, that given a nursing unit of a certain capacity and arrangement and where future expansion is not anticipated, it would be more economical to plan a two-story patient pavilion with two nursing units per floor, than to stack the same four nursing units vertically in a four story scheme. This has been verified on a 100 bed hospital expandable to 200 which was being planned in my office simultaneously with the North Shore project.

The community is given to understand that the plans represent a hospital of 157 beds in anticipation that most of the rear block of five two-bed rooms will be used as single rooms. However, this being a new hospital, no one knows

what the relative demand will be as between semiprivate and private beds. In the meantime, for purposes of equitable comparisons with other published projects, it is reasonable to count the double rooms as double and not as single rooms.

On this basis the hospital as designed and containing 1,215,210 cubic feet would come to 6677 cubic feet and 592 square feet per bed. This compares with the national general average under Public Law 725 of 607 square feet per bed, or an average of 476 square feet for three hospitals of from 125 to 275 beds.\*

We believe it is appropriate to compare hospitals on their cubage or square footage per bed, rather than on the basis of cost, as costs vary widely with the locale and the building market at a given time. For instance as of December 1950 the construction cost indexes of the F. W. Dodge Corporation for building types that would include hospitals, stood as follows:

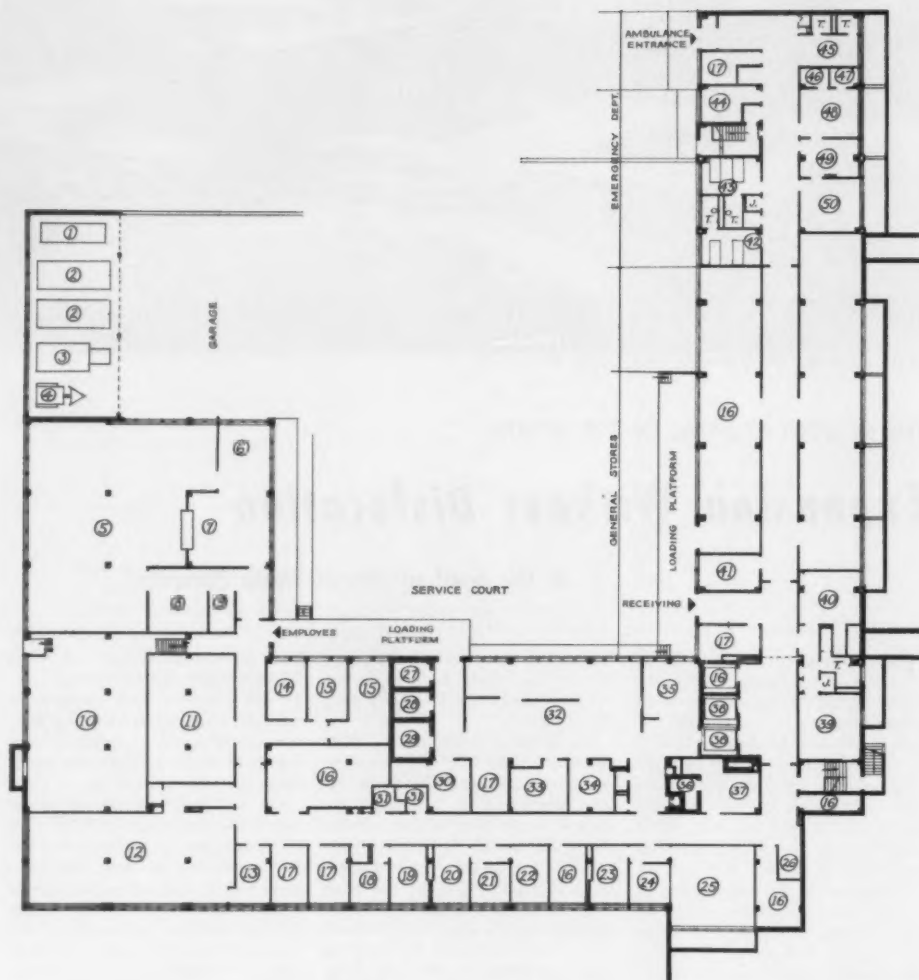
New York .....	258.5
St. Louis .....	229.9
San Francisco .....	228.4
Atlanta .....	195.3

(Continued on Page 69)

### ISADORE ROSENFELD

Architect  
New York City

\*"National Construction Costs," Division of Hospital Facilities, U.S.P.H.S., Hops. 24:37 (April) 1950.



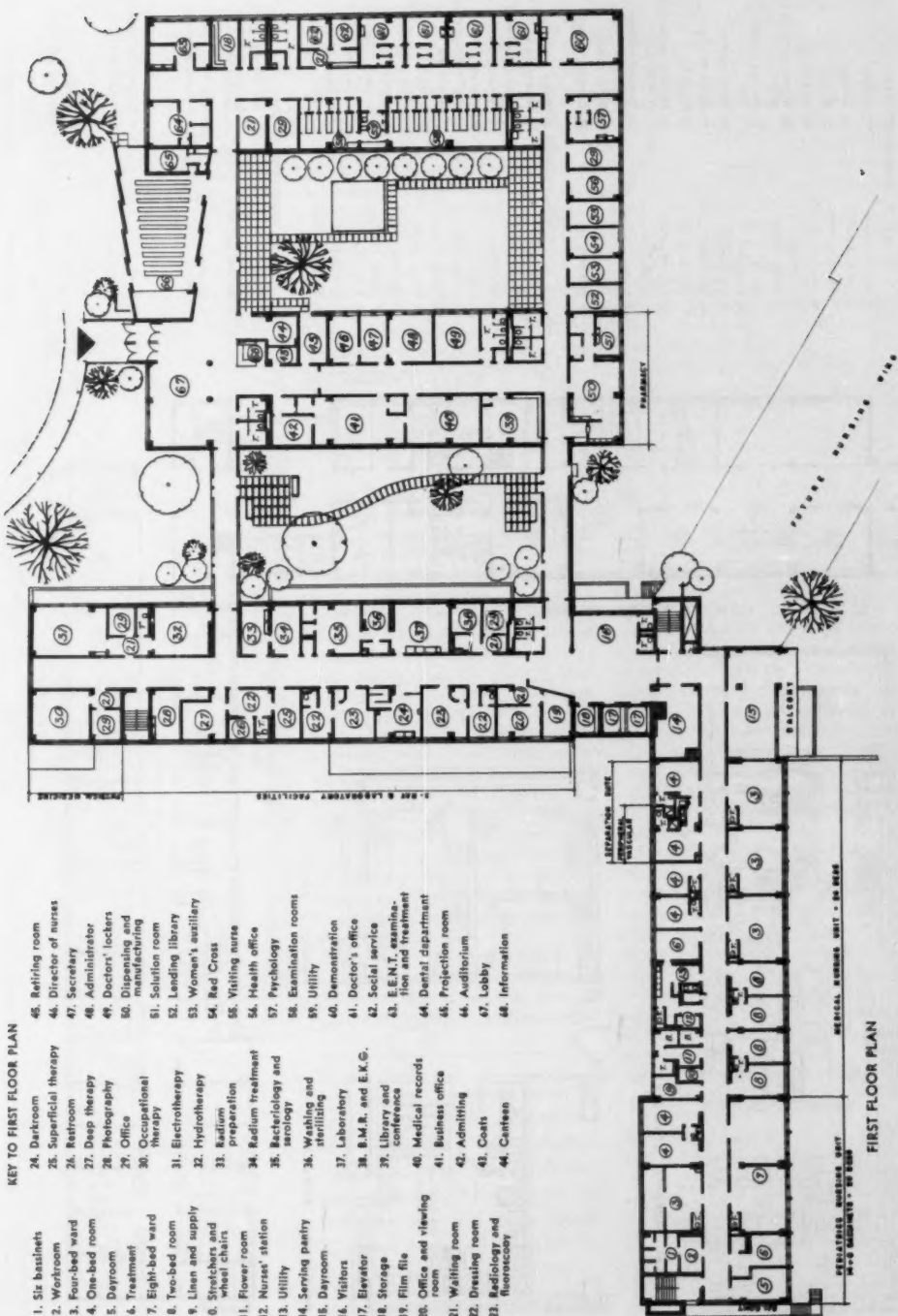
GROUND FLOOR PLAN

KEY TO GROUND FLOOR PLAN

1. Pit
2. Ambulance
3. Truck
4. Snow plow
5. Laundry
6. Sewing
7. Clean linen
8. Sorting and marking
9. Control
10. Boiler room
11. Mechanical equipment
12. Employees' cafeteria
13. Dishwashing
14. Engineer's office
15. Shop
16. Storage

17. Office
18. Male employees' lockers
19. Male employees' toilet
20. Female employees' toilet
21. Female employees' restroom
22. Female employees' lockers
23. Nurses' toilet
24. Nurses' restroom
25. Nurses' lockers
26. Ice flaking machine
27. Dairy refrigerator
28. Vegetable refrigerator
29. Meat refrigerator
30. Dairy stores
31. Chute rooms
32. Kitchen
33. Diet kitchen

34. Employees' dining area
35. Cart washing and storage
36. Garbage refrigerator
37. Incinerator
38. Elevator
39. Necropsy room
40. Morgue
41. Oxygen
42. Two-bed room (women)
43. Two-bed room (men)
44. Interns
45. Waiting room
46. Splints
47. Plasma
48. Milder operating and fracture room
49. Utility
50. Minor operations



# KEY TO FIRST FLOOR PLAN

1. Six bassinets
2. Workroom
3. Four-bed ward
4. One-bed room
5. Dayroom
6. Treatment
7. Eight-bed ward
8. Two-bed room
9. Linen and supply
10. Stretchers and wheel chairs
11. Flower room
12. Nurse's station
13. Utility
14. Serrano pantry
15. Dayroom
16. Visitors
17. Elevator
18. Storage
19. Film file
20. Office and viewing room
21. Waiting room
22. Dressing room
23. Radiology and fluoroscopy
24. Darkroom
25. Superficial therapy
26. Restroom
27. Deep therapy
28. Photography
29. Office
30. Occupational therapy
31. Electrotherapy
32. Hydrotherapy
33. Radium preparation
34. Radium treatment
35. Bacteriology and serology
36. Washing and sterilizing
37. Laboratory
38. B.M.R. and E.K.G.
39. Library and conference
40. Medical records
41. Business office
42. Admitting
43. Coats
44. Canteen
45. Retiring room
46. Director of nurses
47. Secretary
48. Administrator
49. Doctors' lockers
50. Dressing and manufacturing
51. Solution room
52. Landing library
53. Women's auxiliary
54. Red Cross
55. Visiting nurse
56. Health office
57. Psychology
58. Examination rooms
59. Utility
60. Demonstration
61. Doctor's office
62. Social service
63. E.E.N.T. examination and treatment
64. Dental department
65. Projection room
66. Auditorium
67. Lobby
68. Information

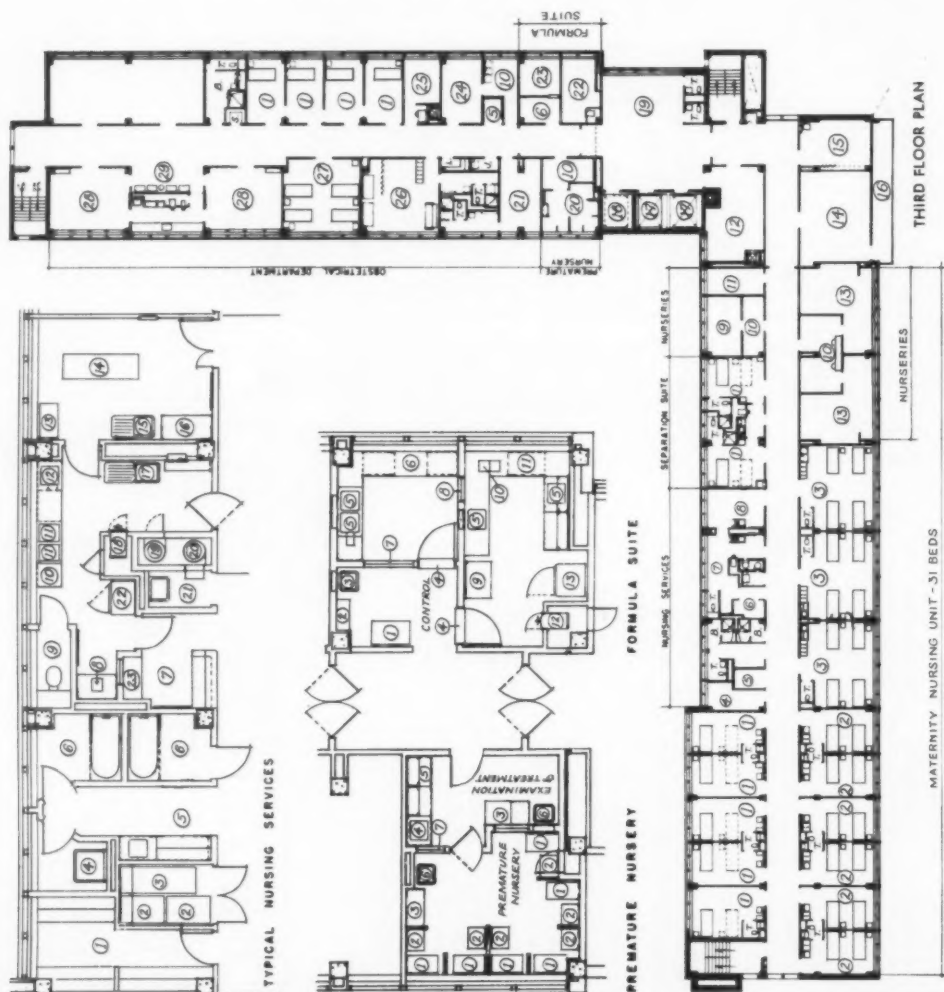
## FIRST FLOOR PLAN

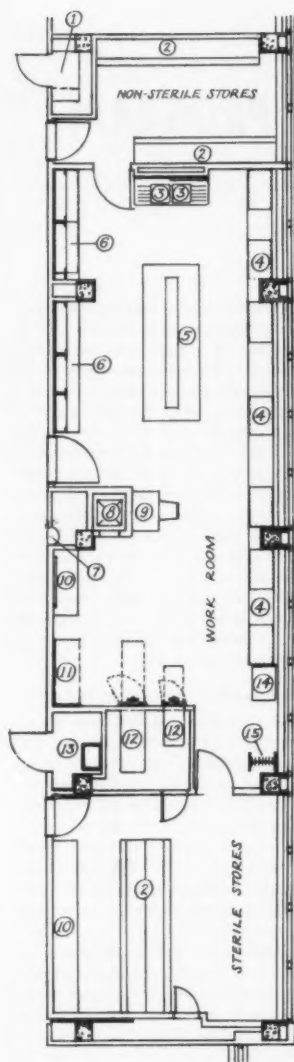
- KEY TO THIRD FLOOR PLAN**
- One-bed room
  - Two-bed room
  - Four-bed room
  - Linens and supplies
  - Stretchers
  - Nurses' lounge and lockers
  - Utility
  - Treatment
  - Six bassinets
  - Workroom
  - Two bassinets
  - Serving pantry
  - 12 bassinets
  - Dayroom
  - Birth room
  - Balcony
  - Elevator
  - Storage
  - Visitors
  - Six bassinets
  - Nurses' lounge and lockers
  - Formula preparation
  - Bottle washing
  - Sterile storage
  - Superior
  - Doctors' lounge and lockers
  - Four-bed recovery room
  - Delivery room
  - Scrub-up room

- TYPICAL NURSING SERVICES**
- Linens and supply
  - Wheel chairs
  - Stretchers
  - Six bath
  - Flower alcove
  - Tub and shower
  - Nurses' station
  - Sink and cabinet
  - Nurses' toilet
  - Tilting ice bin
  - Utility tables
  - Sink and cabinet
  - Dressing cart
  - Treatment table
  - Instrument sink
  - Alberene stone counter & cabinets
  - Service sink
  - Sterilizer
  - Linens chute
  - Rubbish chute
  - Janitor's closet
  - Refrigerator
  - Counter and observation window

- PREMATURE NURSERY**
- Bassinet
  - Bedside cabinet
  - Counter—cabinet under
  - Sink and counter
  - Refrigerator under counter
  - Lavatory
  - Observation window

- FORMULA SUITE**
- Desk
  - Gown shelf
  - Lavatory
  - Delch door
  - Sinks, counter and cabinets
  - Bottlewashing
  - Observation window
  - Pass window
  - Bottle cart
  - Hot plate
  - Formula preparation
  - Sterilizer
  - Refrigerator





#### CENTRAL STERILE SUPPLY

##### KEY TO CENTRAL STERILE SUPPLY

1. Supply closet
2. Counter and shelving
3. Sink
4. Counter and cabinets
5. Center table—shelves over
6. Counter, shelves and cart storage
7. Drinking fountain
8. Dumb-waiter
9. Desk
10. Counter
11. Sterilizer tray cart
12. Sterilizer
13. Janitor's closet
14. Hot air sterilizer
15. Glove drying rack

Thus, a hospital that could be constructed in the New York area at \$2 per cubic foot would be built at the same time in Atlanta for \$1.51 per cubic foot. However, if each of the two hospitals was planned with a marked difference in the amount of building (square footage or cubage) per bed the resulting cost per bed would be a complex reflecting in part the difference in cost per cubic or per square foot and in part the difference in the volume of the building per bed. The complexes of cost per bed are therefore not comparable, but the volume or area per bed is.

The "basic" hospital is without the garage, the community services, and the department of physical medicine. These are not to be built with the first stage if the bids come in too high. These additive features beyond the basic hospital amount to 163,460 cubic feet.

Yet it is the community services arranged around a patio that make this project unique. The services of which this unit are comprised include the auditorium, the outpatient department, doctors' offices, a demonstration room and various offices such as for the local Red Cross, women's auxiliary, visiting nurses, health officer and the like. The patio gardens, and the extensive glass walls through which they can be seen and the doors through which they will be accessible, should contribute considerably to the relaxed and humanized atmosphere which we hope to create here. Another characteristic worth noting in these plans is the fact that the diagnostic facilities in the community service unit are on the same level with the laboratories, x-ray and physical medicine and that the last three are also easily accessible to the inpatients of the hospital.

The fact that nursing units for inpatients will now and later begin with the ground floor means that about 25 per cent of the load has been removed

from the elevators and fewer elevators need, therefore, be installed.

This project also teaches us that it pays to lay down a well thought out progression of development through two or more stages. It has been shown that the first phase of development of this project in its basic form would come to 592 square feet per bed and that this would involve an immediate extra expenditure primarily because elevators, elevator lobby, visitors' room, day room, serving pantry, stairs and so on are to be used by one nursing unit per floor instead of being shared by two such nursing units, as will be the case in the future when the second wing will be added.

It is also interesting to note that the services included in the first stage of development are rather heavy in proportion to the first increment of beds which they are to serve. This is so because, except for the few things that can be later expanded by simple additions, the principal basic services were made adequate in the first place to serve the ultimate complement of 364 beds. For instance, the spaces and pipes for the boiler plant, kitchen and laundry were made large enough initially so that later only a few pieces of additional equipment would have to be installed. In the case of the operating and delivery departments, the auxiliary services are large enough for the future load. But the departments were also so planned that a pair of operating rooms and at most four labor beds could be added later at the end of the service wing where they properly belong.

It is small wonder, therefore, that (counting a full basement) the space required to provide the second 182 beds with all the additional services would come to a mere 508,000 cubic feet, or 2794 cubic feet per bed, or 261 square feet per bed. Adding this to the basic 182 bed scheme, and this time including the garage, physical medicine and community services, we shall have altogether 1,886,670 cubic feet, or 5184 cubic feet per bed, or 465 square feet per bed.

What it all resolves itself into is this: Either we plan for today only and find it necessary later to destroy values dearly paid for in order to expand and at best get a makeshift, or plan now logically for the future and lay money down for it.

It is my belief that it pays to invest in the future both in money and in smooth function.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.



**Social service joins the team to round out**

## **AN EFFECTIVE CHILD-CARE PROGRAM**

WITH our growth in social understanding, the concept of medical social service as a vital part of the modern group approach to the problems of the patients in our hospitals is rapidly gaining acceptance. Particularly striking examples of the integration of medical social service with the other professional aspects of the hospital are evident in the program offered to children with prolonged illnesses. Much needless disability and suffering can be avoided by this type of team approach which, in a very real sense, constitutes preventive medicine, spotlighting the initial stage of illness at which medical care is most effective.

### **OPPORTUNITY FOR STUDY**

Beth Israel Hospital, New York City, is a voluntary hospital for the scientific study and treatment of acute and, increasingly, of many long-term illnesses. It conducts a comprehensive inpatient and outpatient program for children, which includes a number of specialized medical projects devoted to long-term or recurring illnesses and other handicapping conditions. Some of these treatment projects are not frequently encountered in New York City, and hence they offer a unique opportunity for study and care of disabling conditions. Such projects include cardiovascular research and treatment on an ambulatory basis, cardiovascular surgery for children with congenital cardiac conditions (the so-called "blue babies"), medical and neurosurgical approaches to the problem of mental retardation, and psychiatric services for children with psychosomatic and behavior problems.

Comprehensive and progressive care of these conditions along modern lines emphasizes the necessity of understanding and treating the child as a person

rather than the limited diseased part. This is an instance of the whole being greater than the sum of its parts, and an attempt is made to treat the whole patient—his environment and emotions as well as his medical condition. Consequently, there is an increasing trend to coordinate all the forces of the hospital—medical, nursing, and social—in an earnest effort to understand the sick child and to help him achieve a useful and productive life. To attain this end, the team concept is employed, with mutual understanding on the part of all participants of the problems and objectives.

It is in this sense of understanding the child as a member of his family and community that we begin to appreciate the various factors in crippling or potentially crippling conditions affecting the child, which bring in their wake serious, and all too frequently tragic, consequences for the child and his family. This approach has alerted us to the necessity of attacking the problem of prolonged illness in its initial stage, when evidences first appear, and thus preventing or minimizing unnecessary and often irreversible ravages and deprivations.

Comprehensive care in this sense is the responsibility of the hospital. From the point of view of the physician and the administrator, it is necessary to place the greatest emphasis on the prevention of long-term illness, the major problem in medical care today. Lack of such initial care for the child means wasteful use of clinic resources and ultimately of hospital beds.

Outpatient care is becoming increasingly costly, largely owing to progress in medical knowledge and technics in the treatment of chronic illness. The diagnosis of certain of the long-term illnesses is difficult to establish, especially in the psychosomatic group where emotional, environmental and economic factors play a definite rôle. However, it must be borne in mind

that multiple laboratory tests and other costly diagnostic procedures, limited to assessing the organic state, cannot take the place of a sound assessment of the emotional and social factors. Likewise, from the community standpoint, failure to understand the child and his problems often means uneconomical and unwise use of community resources. For example, community experiences show that children with cardiac conditions are repeatedly admitted to convalescent facilities when strains in the home have aggravated a stabilized condition. How much wiser it would be, from every standpoint, if the family received help in time to ease the home problems!

### **REORGANIZED THE DEPARTMENT**

It was with this awareness of the principles of modern planning that Beth Israel Hospital undertook to find ways of increasing the effectiveness of its medical program by the reorganization of its social service department. It seems appropriate at this point to comment briefly on developments to date in the formulation of this program.

In reorganizing this department, which was founded in 1907, we were guided by the desire to develop an inclusive program of medical social service. This meant that professional personnel had to be trained and its responsibilities limited to specified case work assignments. The case load for each worker had to be reasonably limited to ensure effective and continuing care, according to the needs of the patient and his family. Moreover, she had to be allowed adequate time to work with doctors, nurses and community agencies. In planning the assignment of the workers, we had to give consideration to time for dictation, conferences with supervisors, meetings and a variety of other specific responsibilities that a case worker is required to carry. Obviously, adequate provision of space and privacy

From a paper read at symposium on "Chronic Illness: Medical Social Priority," held under the auspices of the Medical Social Service Council of the United Hospital Fund, New York, 1950.



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for comfort and warmth in interviewing was also essential. In short, administrative considerations are not unlike those applying to the educational programs and work assignments of doctors, nurses and other professional personnel, with the director of the social service department on a par with the other administrative officers of the hospital and responsible to the executive director.

Such a program is bound to have a perceptible impact upon a hospital's budget. However, real economy can be measured only by the extent to which effective help is given. It is important that the social service department be supported through the regular budget of the hospital, not through uncertain extra-budgetary funds, although grants for special purposes can always be used advantageously to supplement the department's activities.

Beth Israel Hospital offers help with social problems in a specified group of pilot child-care projects. Four such programs are now in operation; these are the clinics serving mentally retarded children, the children's cardiac clinic, the children's allergy service, and the psychiatric clinic for children.

Of course, case work services are also available to the other patients in the hospital and clinic, but on a referral basis.

**ORGANIZATION AND PROCEDURES**

Basically, all four projects are similarly organized. They provide an integrated teamwork approach, including the services of specialists in the respective fields. A social worker is assigned to each project, and a psychologist is available for psychological testing if indicated. Psychiatric consultations and therapy, and clinical departments, such as physical medicine, dental, orthopedic, neurological and others, are used as the need is individually determined. This is a form of

group practice which operates with a shared responsibility, each of the specialists contributing to diagnosis, treatment and rehabilitation, as required.

The social worker's rôle in the diagnostic process is to provide the information on the child's personality and attitude toward his illness, his interests and activities, the attitude of the family toward the child and his illness, relationships within the family, the economic situation of the family, and the physical setup of the home. This information is obtained by working with the patient, the parents—usually the mother and the father, and where indicated, the brothers and sisters. In addition, the medical social worker continues her service to help patients and their families with such social problems as occur at any stage of medical care in the hospital or the outpatient department. She helps the patient in his adjustment to hospital or clinic care. The frequency of interviews is determined by the nature of the problems. Continued help has been found to be indicated in all the projects; such continuity in service gives the worker an opportunity to consider social and educational rehabilitation plans, so that activities in these areas may be started at the earliest possible moment. Obviously, the full cooperation of the family and patient is required if medical treatment is to proceed satisfactorily.

A chronic illness is invariably an agonizing experience, which leaves in its wake a number of serious social problems for the family. Indeed, chronic illness in any one member may frequently shake the stability of the family group. Joint discussions with the doctor and parents tend to mitigate the shock and anxiety. Parents learn something about what the medical procedure means for the welfare of the child, what the hospital can do, and what will be expected of them. In a number of cases it has been necessary to help families plan for financial aid to meet additional expenses incurred by the child's care at home, for nursing service, and domestic help to relieve the mother of overburdening activity. Continuing help is also needed by the family to ease family tensions.

This kind of program requires close coordination with community resources. Additional services, such as nursing, home teaching, recreational and occupational therapy, are found to be frequently needed and are arranged for where indicated. Close con-

tact with school principals and teachers is important when problems of adjusting school schedules to release pressures and behavior difficulties need to be worked out.

**PROJECT ON MENTAL RETARDATION**

The project on mental retardation is devoted to the study of children with retarded or arrested development of their intellectual and social growth. It offers a two-way approach, both medical and surgical. A group approach was developed because of the increasing recognition by the doctors of the seriousness of the social problems encountered during the provision of medical care. It was found, for example, that most of the parents were unable to acknowledge even to themselves that their children were seriously handicapped. Some of them had not previously been informed honestly of the nature of the child's problem.

Twenty-five children are presently under active care, 13 under medical treatment, and 12 who have had surgery. These children range in age from 2 to 15 years.

In the nonsurgical group of 13 children, four were discovered to have organic findings which could account in part for their arrested development; the remaining nine patients were apparently free of organic defects, but presented complaints of arrested intellectual development, headaches, restlessness, inability to dress and feed themselves, and poor coordination. Six of these children were of school age, but were doing extremely poor work. Some of them were in special classes for the mentally retarded; others were submerged in regular classes and were challenged far beyond their capacities.

Observations by the physicians, extensive psychological technics, and social service assessments of the conditions surrounding each child indicated that for all of them there were environmental and emotional factors to be resolved in attempting a dynamic program for their care. The social worker discusses with parents in concrete terms their relationship to and management of their children, thereby attempting to lessen their pressures. She also gives tangible practical help with problems of school adjustment, often planning with teachers or principals, or helping parents, usually the mother, to handle the school situation directly. Referrals are made to other agencies for aid with housing problems, relief

for day nursery or after-school care of the patient and other children in the family, for social outlets for the parents or for marital counseling service. Camp care as a therapeutic measure is being arranged for seven of the children who benefit from supervised group living away from home. Special camps are utilized where the children will receive individualized help in their adjustment. Three of the children are under psychiatric care in the child psychiatry clinic.

Surgical intervention, designed to increase blood flow to the brain, is an experimental procedure, and the outcome as yet cannot always be determined. This technic has been introduced to the hospital too recently to permit any forecast as to the lasting benefits to be derived, but experience in Cleveland, where this surgery (carotid-jugular anastomosis) was initiated, indicates that it may favorably affect the outlook for these children.

The 12 surgical patients are all seriously retarded, with intelligence quotients below 50. These children have organic conditions caused by brain injury, congenital malformations, and so on. Some of them cannot undertake even the simplest activities in self-care. All had been under treatment elsewhere and came to Beth Israel because of their parents' unending search for help.

The problems for the children and parents in this group are similar to those of the children under medical supervision, but more exaggerated. For some of the children, placement in special schools is being considered or planned with the parents. A few of the parents, who can afford to pay for such placement, are referred to private schools carefully selected by the social worker, who forwards full medical and social reports to the school. Arrangements have been completed for the placement of three children for training purposes in a state school.

#### ALLERGY PROJECT

There are 25 children in this group, ranging from 3 to 13 years, who are being treated for asthma, hay fever, and allied illnesses. The child with allergic illnesses presents a complex situation to the physician, which often makes a clear and firm diagnosis and effective treatment difficult. Experience indicates that there is no single skill or method of treatment for helping these children and their families.

The interplay of physical, social, psychological, and economic forces requires that the internists, psychiatrists, and medical social workers work closely with the child and family.

In planning for these children and their parents, it soon became evident that emotional and family problems often handicapped the child's ability to carry through with the recommended medical plan. The physician in charge of this project is keenly aware of the serious impact of such disturbances and realizes that dynamic medical and social planning can alleviate and in some situations remove the physical symptoms. It is planned to use psychiatry more extensively in this program.

Careful social study and assessment, in combination with medical findings, in a small group of children indicated serious social disturbances. Three of the children were in school and were either considered slow in learning or presented behavior problems. In one situation, a serious marital problem was found to be at the root of the child's difficulty of adjustment to medical care. In this case, the parents needed help in recognizing how their unstable relationship affected the child, and they accepted referral to a family case work agency.

#### CARDIAC PROJECT

This project treats children with congenital and rheumatic heart disease, rheumatic fever, and other cardiac conditions. Often the diagnosis is difficult to make and requires careful observation and an understanding of the full situation of the child and family. The most dangerous characteristic of cardiac disease is its tendency to become chronic, with frequent and increasingly serious relapses. Preventive measures require thorough physical and social diagnostic study, continuity of medical and social service supervision, and wise use of community facilities. Prolonged hospitalization when necessary and careful nursing are essential for protection against renewed infection.

There are 69 children under clinic supervision. As yet, only a small proportion of these are included in the group project, which was started recently when it was realized that many of the children were making slower progress than was warranted by their medical findings.

The patient and parents were found to require help with emotional adjust-

ment and an understanding of the physical condition; this basic educational process is handled jointly by the doctor and social worker. We believe that an effective program along these lines will prevent tomorrow's cardiac cripples.

Because of the long period of bed rest required during convalescence, many of the children cannot be effectively treated in homes of substandard economic levels. Parents receive help directly through hospital resources or by referral to community agencies which will help meet this deficit in the home. Case work counseling is offered the parents and child if their relationship is poor. Referrals have been made to recreational, cultural, and socialization resources of those children who can be active outside of the home—or these are brought into the home, when available, if the child is home-bound.

#### CHILD PSYCHIATRY SERVICE

The child psychiatry service was recently reopened to provide diagnostic consultation and therapy. The team is composed of a child psychiatrist (a psychoanalyst), a lay therapist, a psychologist, and a social worker. Treatment is offered to children with psychosomatic and behavior problems. As indicated earlier, children with organically caused emotional problems, for example, those following brain injury, are accepted provided their prognosis is judged to be favorable. Each child is seen weekly for half or three-quarters of an hour. The parents are interviewed at least once by the psychiatrist. Follow-up work with the parents is done by the social worker in conjunction with the psychiatrist.

Group meetings of this team are held every second week, to discuss each individual child, his progress or lack of progress, and family developments. Plans are jointly outlined at these meetings as to procedures for each member of the team.

The projected plan for the early extension of the services of this clinic envisages a staff of three experienced psychiatrists, two lay therapists, one social worker, and a psychologist. The clinic sessions will be increased to twice weekly, with each child being seen at every session. A program of group psychotherapy is planned as an integrated unit, with individual psychotherapy for some children. Group therapy will also be provided for the parents.

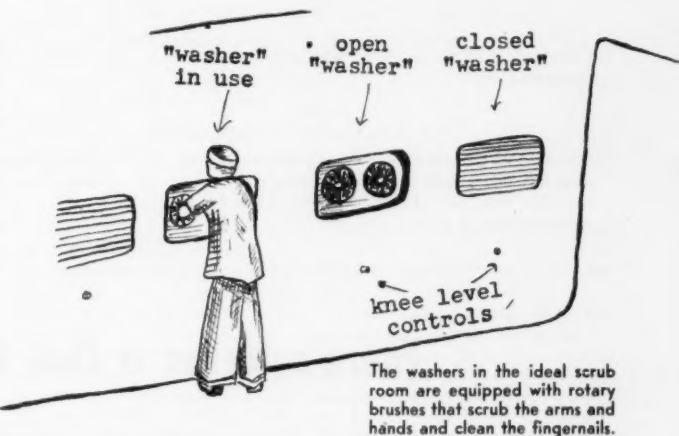
# An O.R. Supervisor Can Dream—and Does

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THE operating suite is an important element as one of the hospital's principal therapeutic services. Its requirements are complex, its traditions exacting and, as a result, its design generally conforms to accepted standards, but its possibilities are still challenging. Understandable concern for the patient's welfare prompts close scrutiny of any proposal to deviate from standards, and the need for economy in one of the costliest parts of the hospital tends to discourage experimentation; nevertheless, it is evident that research is still needed to provide for greater efficiency in the operating room as is exemplified by the wasted manual labor resulting from inconveniences, and by the accidents that occur in the operating room each day.

To achieve the ideal operating room the architect who is designing the hospital should definitely have the help of the personnel that will work in his building. In planning an operating room the entire operating staff of surgeons and supervisors should be consulted, and in addition, the staff nurses and attendants should be given the



The washers in the ideal scrub room are equipped with rotary brushes that scrub the arms and hands and clean the fingernails.

opportunity to add their suggestions. Ideas should be collaborated upon and a definite standardization of technics worked out which will be adhered to. The operating rooms should then be planned to meet the needs of the staff and hospital, with the idea of future expansion always in mind.

The accompanying description of an

ideal scrub room is one of the improvements I believe would follow such a coordination of the thoughts and ideas of all of the individuals concerned.\*

\*This is the first in a series of "ideals" for operating rooms proposed by Mrs. Blizzard. Others will appear in subsequent issues of this magazine.—Ed.

## SCRUB ROOM

### RECOMMENDATION

Provides scrubbing facilities for two operating rooms.

No street clothes are allowed in the operating room or adjoining corridors. Street clothes are changed in the dressing rooms (which are near the elevators or stairway). Caps and masks are also put on in the dressing room.

The scrub room is entered from the corridor.

The scrub room contains sets of two washers which are built in the wall. The doors of a pair of washers slide open by a knee control button. The arms are put in the washers. The inside of each washer is equipped with brushes which push back as the hand and arms enter to adjust to the size of the extremity. These rotary brushes scrub the arms and hands and clean the nails while soap and water are sprayed.

### RESULT

Eliminates danger of contamination from street clothes.

Eliminates unnecessary traffic through operating room.

No "stopped up" sinks.

No splashed soap and water on the floor.

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The washer automatically stops after three minutes. As the scrubbed arms and hands are taken out of the machine the doors slide closed and the inside and brushes are automatically sterilized by high pressure autoclave apparatus for three minutes. After the autoclave apparatus is finished the knee button control can again be used to open the doors; the button will not open the doors until the sterilization of the washers is complete.

The controls are all set up in the workroom below the operating room.

When the scrub is finished the operating room is entered through a sliding door which is opened by an electric eye. The door goes directly from the scrub room into the operating room.

Time saving. Less time needed because all parts are scrubbed three minutes instead of dividing a 10 minute scrub over two extremities.

No chance for contamination.

Everyone is thoroughly scrubbed.

No attendant is needed to clean and sterilize brushes, or clean messy scrub sinks.

Longer life for the brushes as there is no mishandling of them.

No repair men in the operating rooms.

Scrubbed hands are not exposed to contamination when surgeon walks across corridors, and so on.

## There's Never a Dull Needle

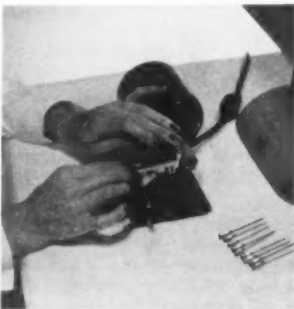
THE Jacoby needle sharpener has been in daily use in St. Luke's Hospital for more than two years. Like many other hospitals, we had frequent complaints of dull needles from doctors, nurses, and patients, and had tried several methods of sharpening without satisfactory results. When Dr. George Jacoby, formerly a resident on our staff, demonstrated his new precision needle sharpener, we were impressed with its possibilities. To say the least, we are pleased with the results!

From the humanitarian point of view alone, the machine has paid for itself, as many patients have commented on the marked improvement in the needles. In the past, much time was lost because of dull needles. Tempers have improved with sharper needles available; thus, much valuable hospital time has been saved. Many needles which were too badly damaged to salvage under our old methods are now retained. Burrs are removed much faster and the needles are sharpened at the same time, thus providing reserved needles to the divisions which are equal to, if not better than, new needles.

This needle sharpener is extremely easy to operate and we have found that it takes little time and supervision to

instruct lay people how to use it. One outstanding feature we like is that the machine uses abrasive sleeves which are easily replaced by the operator. With these abrasive sleeves, a high smooth polish is obtained and it is impossible to burn the needle point. Maintenance for the machine consists of an occasional oiling. There have been no breakdowns.—BARBARA LATIMER, supervisor, central supply department, St. Luke's Hospital, Cleveland.

*(Additional information regarding the economics of the needle sharpener is offered in the following comment from D. A. Endres of Youngstown, Ohio.—Ed.)*



The sharpener is easy to operate.

IN OUR situation the purchase of this machine has proved to be an economical move, founded on several considerations. Based on purchases covering the last two years (1949-50), during which we have used this machine, we have been able to reduce our yearly needle purchases by \$184. This amounts to a reduction of approximately 18½ per cent.

As to the relative labor cost, one employee is used on a full-time basis to operate the machine. This employee does not represent an increase in C.S.R. personnel; rather, it is a revision in the allocation of labor. Previously, several aides worked part time on sharpening needles, now one does all the sharpening.

Five hundred needles are sharpened daily, approximately twice the number reclaimed prior to the purchase of the machine. The labor cost per needle reclaimed and sharpened is \$0.012. With the present number of needles reclaimed, another aide would be required if the needle sharpener were not in use.

A training period of two weeks is required before an employee can operate this sharpener to its full advantage.—D. A. ENDRES, superintendent, The Youngstown Hospital Association, Youngstown, Ohio.

# Good Nursing Starts at the Top

*the director of nursing must have a thorough understanding of the nursing needs of all patients and the ability to plan the work of her department*

MARGARET J. DENNISTON, R.N.

Chicago

THERE is no need to emphasize that there is a shortage of well qualified professional nurses who have grown and kept in step professionally with the onward march of medical science. Complacency has no place in professional nursing. Unless the nurse understands what is happening to her patient chemically, physiologically, anatomically, emotionally and socially, she is unable intelligently either to direct or to give good nursing care; therefore, it behooves us to look objectively at changes and confine her function and responsibility to those which are essentially of a nursing nature. The nurse will give better patient care through better nursing when she is allowed to do only that for which she has been specifically prepared—nursing the patient.

## OUTLINE STANDARDS

In attempting to reach her goal of expert bedside and specialized nursing care for her patients, the director of nursing must outline standards of performance and provide the means of their achievement through:

1. An adequate number of professional nurses to perform as assistant directors, supervisors, head nurses, and general duty nurses.
2. An adequate number of auxiliary workers, who may be licensed practical nurses, ward clerks, trained hospital attendants, or trained orderlies.
3. Adequate amounts of medical and surgical supplies.
4. An adequate amount of specialized equipment and a good inventory system.

If the director of nursing provides adequately for each member of the nursing staff to work efficiently, she should also allow herself and her assistants time to organize, to think, to plan and to initiate research projects and time studies with the aim of increasing efficiency and giving better nursing care through economy of personnel, time, effort and supplies. She should keep in mind that no executive is successful unless she is able to teach and to stimulate initiative. Furthermore, no executive should do a sub-

ordinate's work; therefore, the director must know how to delegate responsibility to those who have adequate preparation and are able to assume responsibility at different levels. An unhappy staff reacts unfavorably on patients; therefore, an adequate budgetary allotment will help her to keep her staff happy through the institution of good personnel policies, adequate salaries, hours of work, vacation, holidays and sick leave, good dressing and rest rooms, good food and housing at reasonable cost. A good health service and adequate number of personnel on each unit to do good nursing will unquestionably reduce the number of sick days and thus increase efficiency and reduce costs.

Each member of the nursing team should be imbued with the true spirit of nursing, which I believe includes:

1. A wholesome attitude toward nursing and life in general.
2. A love and kindly understanding of people, especially sick people.
3. A willingness, when the need arises, to sacrifice one's own time in the interest of the patient and the institution one serves.



4. Keeping ever before one the precept, "Whatsoever thou doest, do it with all thy might," and the Golden Rule.

5. Having a joy in achievement and overcoming difficulties, feeling that the main reward lies in having played a part in the restoration of the sick individual to health, home, happiness and a life of usefulness in the community.

## DEVELOP PROPER ATTITUDES

During the embryonic or student stage of nursing there is a golden opportunity for the development of these attitudes in qualified young women, but unless students are able to see good nursing and wholesome attitudes in operation on the wards, faculty members will have a difficult time developing them. Hence the importance of a sound nursing educational program and an adequate nursing staff to provide good nursing. Today's student is tomorrow's employee; therefore, the director of nursing must endeavor to show the new employee what is expected of her. In general, this must be done in the following steps:

1. An explanation of the organization as a whole, showing lines of authority, the opportunities for advancement and promotion within the ranks whenever possible.
2. A written outline of personnel policies, with a written outline of the nurse's duties and an explanation of the merit rating system.
3. An explanation of the hours of work and the importance of treating all personnel alike in the matter of hours on duty, in caring for the patient.
4. Assurance that an in-staff educa-



tion program is in operation and the nurse will be given an orientation to the unit, with an explanation of procedures and a tour of the hospital and its various departments.

5. Assurance that, if she ever needs help and the head nurse or supervisor is off duty, there is always someone in the nursing office to whom she can turn for help.

6. Assurance of the fact that the nursing office door is wide open and problems which cannot be handled satisfactorily by supervisors or head nurses will always get a fair hearing by the director of nursing or one of her assistants.

7. Showing the importance of human relations, interdepartmental relations and public relations in the total program of better patient care through better nursing.

8. Emphasizing the need for economy and the many ways in which the nurse can foster this and bring down costs without jeopardizing patient care.

#### **WATCH NURSES' WELFARE**

As the director of nursing and her assistants make rounds of the hospital and observe patient care, they must not lose sight of the nursing staff in the various units. They must maintain a friendly interest in their welfare—observe their work and make comments on either good or poor performance, always bearing in mind that a word of praise often stimulates greater effort. In order that nurses may have an opportunity to air their grievances, to take part in planning, to initiate changes for better nursing, and to make everyone feel that she has an important rôle in providing better patient care through better nursing, regular staff meetings for all grades, including practical nurses and orderlies, should be held. The time and place for these meetings should be posted for the entire year.

Good organization and personnel management must prevail within all nursing units and begins with uniformity—a place for everything and everything in its place. Placement of equipment and supplies should be uniform in all nursing units, including operating and delivery rooms. Cabinets in specified locations should be clearly marked with their main contents. Nursing procedures should be uniform, and all nursing personnel should be familiar with the location and use of the administrative policy book, the ward manual, and the pro-

cedure book, which must be kept up to date on all nursing units.

The director of nursing and her assistants must keep in step with all advances in medical science and endeavor to keep their staff up to date. This is done through:

1. A staff education program for all grades of nursing personnel. They must be able to interest the medical staff in this program and through staff cooperation assure better patient care through better nursing.

2. The staff education program should include a course in supervision and ward management for all head nurses who have not been exposed to a similar course elsewhere. This will clarify their responsibility as admin-



istrators, teachers, sanitarians, public relations officers, morale builders and personnel managers with a knowledge of the philosophy of democratic leadership, as well as the technic of dealing with others and motivating them to take pride in their work and to give the best care of which they are capable.

The supervisor and clinical instructor are important in their specialized fields in fostering better patient care through better teaching and better nursing, but there is no one person, with the possible exception of the night supervisor, who is in a more strategic position to stimulate the student and bring about better patient care through better nursing than the head nurse. She is the liaison officer among the doctor, the patient, his relatives and the general public. She is the person who can radiate hope, cheerfulness, human interest, sympathetic understanding and hospitality, as well as the efficiency of the institution.

She must be an expert bedside nurse who knows good nursing and who can set the pace for others by insisting on high standards of performance and, through incidental teaching and a planned ward teaching program, impart the secrets of maintaining high

standards of patient care to students and other nursing personnel, including the private duty nurse. She must also be able to demonstrate complicated procedures and to answer questions intelligently pertaining to patients, community resources and methods of referral.

The head nurse must be able to teach tact, diplomacy, patience and kindness in dealing with doctors, patients and their relatives. Above all, she must know how to supervise and stimulate professional growth and avoid antagonistic reactions. If she does not have an assistant, she must train her general duty nurses to act in her absence just as efficiently as if she were on duty. She must foresee the amount of drugs, linen, medical and surgical supplies required to cover each 24 hour period and order accordingly. She also has the responsibility of initiating and continuing an economy program, including economies of time, energy and equipment. She must be aware of the legal importance of safety, and be able to initiate a program for the prevention of accidents.

#### **NEEDS UNLIMITED ENERGY**

Through all this, the head nurse should be able to retain her sense of humor and make allowances for the strengths and weaknesses of human nature. In order to do this effectively, she requires an unlimited amount of energy, both physical and mental. In my opinion, few human beings could equal the performance of a head nurse on a really busy day on a ward for the acutely ill, where all kinds of tests and research are going on, plus medical rounds, medical student clinics and anxious relatives to be put at ease—with the staff below the minimum for safety!

Effective management is accomplished only by making definite plans to achieve desired results. When aims are clear and policies plainly outlined, plans must be made for carrying them out. This includes planning for the individualized nursing care of each patient, which means mental and emotional as well as physical care. The head nurse must have a thorough understanding of the nursing needs of all patients and all the duties to be performed by her staff before she can adequately plan for written personnel assignments and thus know on whom responsibility is placed. This is the key to better patient care through better nursing.

## Hospital and university collaborate on

# a program of **IN-SERVICE TRAINING**

**L**AST year was a banner training year for the Philadelphia General Hospital, one of the oldest and largest in the nation. This hospital has turned its attention to in-service training programs for office, technical, medical records, maintenance and other types of employees in order better to meet the needs of the institution. In 1950 2000 man hours were spent in classes under my direction as representative of the management services division, Community College of Temple University.

At the request of Dr. Pascal F. Lucchesi, superintendent and medical director of the hospital, a program of in-service training for medical record clerks was developed to cover an eight-week period. Meetings were held at the hospital twice each week for 1½ hours. All employees in the record room took the course at the same time. The Temple University short-course certification in medical records was granted each student at the end of the course.

### **PRACTICED CODING OF DISEASE**

At least one-third of the sessions were devoted to practice in the coding of disease by use of the book on standard nomenclature. Discussed in the course were such topics as the history of medical records; value and importance of medical records to the patient, hospital and community; anatomical classification as related to the standard nomenclature; record room procedures, and the various files in the record room.

Several periods covered human relationships, good and bad supervision, and the importance of lay personnel's getting along with professional employees of the hospital. It was pointed out that medical record personnel must know how to point out tactfully shortcomings in the medical charts turned in to the office. The instructor attempted in all sessions to stress the importance of the job and to build pride in work and, consequently, good morale.

### **EDWARD B. SHILS**

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Inasmuch as this course was given during regular working hours and the record room was to be closed for three hours per week, the instructor asked the students to cooperate by not letting their regular work slide. It was a matter of pride to the entire class that at the end of the eight-week course the work was entirely current despite a slight increase in volume. Many employees expressed interest in taking the medical records examination for registration as a registered medical record librarian.

It is axiomatic in personnel administration that an employee who has an intelligent understanding of his work can do a better job. Employees in the medical record room who had been handling codes and files in a routine, bored manner now began to see the anatomical clarity behind the topographical and etiological codes. Numbers which had just been numbers now began to be meaningful in terms of related diseases. After the course was completed, the medical staff began to realize that it too had to be more accurate in making entries on the medical charts, since clerks who formerly had never doublechecked for errors in the charts now began tactfully to point out errors of omission or commission to the supervisors and, in many cases, to physicians themselves.

Morale improved to such an extent in the medical record room that Dr. Lucchesi next asked the management services division to plan courses for hospital employees in general.

A program was established which could cut across departmental lines and meet the principal needs of the hospital. Dr. Lucchesi was extremely anxious that the next program should stress human relations. It was also

decided that films would be used wherever possible to teach lessons in good human relationships without creating over-sensitivity in the students.

The first in-service course given at Philadelphia General Hospital for employees of all divisions and services had 25 students, as did the course which immediately followed it. The group met Mondays and Wednesdays from 3:30 to 5 p.m. during regular work hours of the hospital for a period of eight consecutive weeks.

### **REPRESENTED MANY DIVISIONS**

Students in the program represented many departments and divisions of the hospital: personnel, admitting office, laboratories, medical records, psychiatric wards and clinics, social service, business manager's office, maintenance, pharmacy, accounting and many others. The mixing of students cut across departmental lines and gave background to new employees who did not know what existed outside of their own departments. This is of great importance in a hospital where the patient's welfare depends on the closely knit coordination of all parties to his records, treatment and related care.

Twenty films were used in each of the general courses, and although it was not possible to find films with hospital backgrounds in most cases, nevertheless films citing examples of good and bad supervision or human relationships in other fields sank home with terrific impact. Many of these films had been made by the U.S. Office of Education and the U.S. Navy during World War II.

Sixteen sessions were held. Major subjects discussed were as follows:

1. The community responsibility of Philadelphia General Hospital and the Philadelphia Department of Public Health.

2. Organization and functions of the Philadelphia General Hospital and re-

lationship of the professional to the nonprofessional staff.

3. The Philadelphia civil service system as it affects hospital employees—rights and obligations of each person.

4. The importance of medical and nonmedical records at the hospital; importance to research, vital statistics, hospital progress.

5. Important cogs in the machinery of hospital record-keeping and a brief description of the background of standard nomenclature of disease.

6. The responsibilities and worries of a supervisor.

7. Methods of interviewing the public and people in trouble.

8. Courtesy to the public and fellow employees, also telephone courtesy.

9. Why a supervisor should study his own responsibilities and the importance of a clear line of authority and responsibility from top to bottom of any organization.

10. Giving orders to ensure that they are carried out.

11. Adapting discipline to the in-

dividual; how to correct persons properly.

12. The discontented worker.

13. The care of materials and equipment; proper housekeeping.

14. Problems of the physical plant, the power plant, the laundry.

15. Evidences of leadership; how department heads rate supervisors.

16. Good planning and poor planning. Award of certificates.

Dr. Lucchesi found the response to these training programs so active that plans were made to continue the cycles of training. The management service division of Temple University also discovered that many hospital administrators in the Philadelphia area desired to follow the example set by Philadelphia General.

Since the completion of the third course at Philadelphia General Hospital the university has inaugurated courses at Abington Hospital and also a joint course at the Friends Hospital for employees of both Friends and Frankford hospitals.

In addition to the work going on at the hospitals mentioned, the management services division completed a program on the Community College campus at Temple University for 20 supervisors and administrators representing the following hospitals in the Philadelphia metropolitan area: Chester County Hospital, Jewish Hospital, Presbyterian Hospital, Jeanes Hospital, Mercy-Douglass Hospital, Woman's Medical College and Hospital, Amalgamated Clothing Workers Health Center, St. Christopher's Hospital, Temple University Hospital, Wilmington Memorial Hospital, Associated Hospital Service, and the Children's Heart Hospital.

Temple University and the community are indebted to Dr. Lucchesi for setting the pattern in the training of hospital employees. It appears that the program will continue to spread in the Philadelphia area inasmuch as Temple University is deeply interested in meeting a community need wherever it finds that this need exists.

## ***They Made Hospital History***

# **AMBROISE PARÉ**

**A**MBROISE Paré, born in 1510, came into an upset world, with wars raging intermittently between Charles V of Germany, Henry VIII of England and Francois I of France, and "at a time when the arts and sciences were nearly extinct, when the intelligence of the world was shut up in a cloister, when philosophy was afraid to speak and when the people were devoted more to the pursuits of war than to the cultivation of letters and the advancement of civilization."<sup>1</sup> Only a half century had elapsed since the invention of printing and only 18 years before Paré's birth, Columbus had discovered America. Luther was sowing the seeds of the Reformation, while Copernicus was studying the revolution of the heavenly bodies and true science was beginning to stir in the darkness of the Middle Ages.

Paré was of lowly birth and lacked formal education. Yet because of his technical skill, courage and fine char-

acter, Paré served as surgeon to four kings and brought the lowly practice of surgery to a height it had never before attained. He became the greatest figure in the Renaissance and the leading surgeon of his age.<sup>2</sup>

Paré was born near the city of Laval, just before the death of Louis XII. His father was a boxmaker, a trade followed by one son. Two other sons, besides Ambroise, and a son-in-law became barber-surgeons. Ambroise was sent to the chaplain of a nobleman to be taught Latin, but the chaplain, overworked and underpaid, set the boy to weeding the garden and tending the mule. Paré quit his service and was placed with a barber-surgeon, Vialot of Laval. Witnessing an operation one

day, he determined he would become a surgeon. After studying in Paris, some say with a professor in the College of France, he became a resident student at the noted old Hôtel Dieu. During his active three years of residence there, he obtained much of the skill for which he was later noted.<sup>3</sup>

The College of Surgeons in Paris, established in 1268 by St. Louis in gratitude to the surgeons for their services rendered during the Crusades, was open only to candidates with an academic education. Barber-surgeons were barred, for there was a sharp distinction between the "shavers" and the master-surgeons, the licentiates of the College of St. Comos. Gross<sup>1</sup> states that the familiar pole of the barbers was for-

**OTHO F. BALL, MD.**

President, The Modern Hospital Publishing Company, Inc.

merly the sign of the barber-surgeons. During blood-letting the patient grasped a rod while the arm was tied with a red fillet or a piece of flannel. The operation over, the fillet was twisted around the pole and hung up as a sign to attract customers who desired venesection. Later a pole painted with red stripes placed at the door was the insignia of the barber-surgeon.

When he was 26 years old (1536) Paré became barber-surgeon to Marechal de Montéjan, a colonel general of the French infantry, who was about to march against Emperor Charles V to recover Piedmont and Savoy for Francois I. Because of his skill, he received this appointment although he had not yet passed his examination as a barber-surgeon. Physicians and surgeons at that time were not appointed to serve in the army but became a part of the personal retinue of a general and cared for his staff and his troops. Thus began Paré's long surgical service. For 32 years, he was a surgeon following the army in the intermittent wars. During the short years of peace between, he served an ever-increasing clientele, advanced his learning by study of anatomy and dissection and wrote his many books.<sup>5</sup> In the very midst of political intrigue, he kept aloof from quarrels and perils and faithfully served four kings, Henry II (1552) and his three sons, Francois II (1559), Charles IX (1560) and Henry III (1574). He avoided religious entanglements equally well. Some believed him to be a Catholic, others thought him a Huguenot. His children were baptized and he himself was married twice, in the Catholic church, but some of his writings seemed to indicate that he was a Huguenot.

#### IMBUED WITH RELIGIOUS SPIRIT

Paré in his books gave evidence of being imbued with the religion of the time. Not only did he give credit to God for all his cures, "I treated him, God cured him," but in his treatise on the plague, he stated that the plague came from God as a manifestation of his wrath, but nevertheless warned the surgeon "not to neglect the remedies approved by physicians both ancient and modern; for as by the will of God this disease is sent among men, so by his holy will he gave us methods and remedies to use them as instruments for his glory."<sup>6</sup> He urged that the magistrates should appoint experienced physicians, surgeons and apothecaries



AMBROISE PARÉ  
(1510-1590)

to care for the sick, isolating those with plague either in places set apart for their treatment or shutting them up in their own houses, the latter being less advisable as the patients should hold no conversation with the healthy. Men should be sent to dress and feed them at the expense of the patients if they had the means, or at the expense of the parish if they were poor. Furniture of those dying of the plague should not be sold. Thus we see Paré recommending the establishment of what came to be known as the pest-house, or isolation hospital.

Paré had a fearlessness that was particularly evident in his surgical methods. In the beginning of his practice he followed the accepted rules of treatment. One night after the capture of the castle of Villaine by the French, he had many wounded to treat and, much as he abhorred the practice, he poured the customary hot oil on the wounds before dressing them. Finally he ran out of the oil and had to use an ointment he prepared from yolks of eggs, oil of roses and turpentine. Worrying about these patients, he rose early to visit them and found to his amazement that whereas those with hot oil applications were feverish and in agony, those without oil were fairly comfortable. He determined never again to use that cruel treatment.

The theory at that time was that gunshot wounds were poisonous but when Paré tried to convince the surgeons that there was nothing in gunpowder of itself that was poisonous and that the hot oil was not only brutal but ineffective, he was questioning the knowledge of the accepted authorities and aroused the enmity of the surgeons.

Sylvius, professor of medicine at the University of Paris, was impressed with his success and urged him to publish his methods and therefore in 1545 Paré wrote his book "A Method of Treating Gunshot Wounds." Since he knew no Latin, the only accepted language for the medical books, he wrote in the vernacular and brought a storm of opposition from the faculty of medicine, by which he was called an upstart.

#### QUESTIONED OLD REMEDIES

Paré dared to question other old remedies, particularly the use of mummies and unicorn's horn. In 1582 he declared that the carefully embalmed bodies of the ancients were not meant to be eaten and, moreover, they were much too scarce to be available. He stated that it was common rumor that bodies were taken off the gallows at night, eviscerated, dried in an oven, dipped in pitch and sold as good mummies brought from Egypt by the Portuguese merchants. As for the horns of unicorn, which were sold at immense prices, no such animal existed and the horns of rhinoceroses, or the horns or tusks of any animal, were being sold for their weight in gold. They were absolutely without value as antidotes to poisons, as used by the king. Moreover, he advocated the use of antimony in treatment of plague in one of his books, a drug not favored by the physicians; he omitted mention of the drug in the next edition of his book to prevent further uproar. At another time, in printing a second edition of one of his books, he left out treatment of fevers because the physicians protested that he was entering the field of medicine. Instead, he inserted it in a treatise on tumors and the matter was dropped without action.<sup>7</sup>

While the physicians claimed that this ignorant man was invading the medicinal field, the surgeons were equally opposed to him because of his encroachments. Paré wrote, "I know very well that the surgeons who ought to lend me a hand to hold up my chin for fear I should go to the bottom have wanted to push my head under water to drown me. They have done their best to make me obnoxious to the authorities both of Church and of State, and to the public; they have left no stone unturned to upset me if they could." Later (1582) when Guillemeau published a Latin translation of Paré's collected works, these same opponents were enraged because they thought that only the members of the faculty were

able to translate medical works into Latin.

The faculty members were loud in protest against all his books. The only surgical works available at that time, besides those of Hippocrates and Galen, were by Lanfrance, Guy de Chauliac and John de Vigo, books which Paré had dutifully studied, but none of these compared with the works of Paré.

One of his works which brought the loudest opposition, and which in time brought him fame, described his method of applying ligatures to arrest bleeding in amputations. Up to that time, the hemorrhage was stopped by applications of hot irons, an agonizing process in the days preceding the discovery of anesthetics. Paré did not claim discovery of the ligature, for it was described centuries earlier in tying off injured arteries. Albucasis, living in the 11th and 12th centuries, wrote a book on the use of cautery as a hemostatic agent and, like Gelsus, made reference to use of the ligature, but neither attempted it. As early as 1552 Paré had used ligatures on the battlefield, with great success.<sup>4</sup> At first, however, he kept the irons handy, just in case anything went wrong. The surgeons were heavily opposed to this method and it was held against him that his own brother-in-law had died when the method was used on him. Paré was so vigorously attacked for his presumption after his "Dix Livres de la Chirurgie" appeared (1564) that few of his contemporaries ventured to use his method. It is notable that in describing his method of amputations, Paré pointed out the desirability of cutting the leg off five fingers *breadth* below the knee, even though that removed some healthy tissue, in order to better fit a wooden leg.

#### BECAME MASTER SURGEON

In 1541 he passed his examination and became a master barber-surgeon. The surgeons of that time were ground between the physicians who constantly checked them in any attempt to practice medicine and the barber-surgeons who encroached upon their surgical practice. However, the surgeons did not condescend to operate, leaving all but applications of plasters and ointments, the use of cautery, and treatment of abscesses and wounds, to the barber-surgeon.<sup>5</sup> His next step was in 1554 when at the age of 44 he was made a member of the College of Saint Comos and became a master-surgeon. Violently opposed to him earlier, the

surgeons now were anxious to add to their ranks one who had gained such prominence at court. His examination was a farce, for he was not charged the usual fees and knowing no Latin, he had memorized a Latin discourse which he recited. In 1562 he took the oath as first surgeon to King Charles IX. Up to that time no master-surgeon had served with the troops.<sup>4</sup>

When in 1575 Paré published his collected works, Gournelen, dean of the faculty of medicine, attempted to enforce the decree of 1535 prohibiting publication of a medical work without previously getting permission of the faculty. The College of Saint Comos joined against its own member, Paré. Paré said the physicians were afraid the book, being in French, would be read by the people who would not call the physicians when sick, and the surgeons feared the barber-surgeons would become as skillful as themselves and trespass upon them. However, the book was already in print and widely sold.

Far in advance of his age, he devised various instruments and performed many unusual operations, effecting wonderful cures in his military and civil practice, so that he was widely known for his skill. Many of the vicissitudes of his life are revealed in his "Apologie" put into his collected works (1585). His book on his military journeys is filled with his unusual experiences. He won the devotion and trust of the soldiers.

Generals were continually requesting his presence after a battle or at the time of a siege. During the siege of Metz (1552) the Duke of Guise asked the king to send Paré in with an ample supply of drugs. Paré slipped into the city and immediately set to work. On his return to Paris the king rewarded him generously. He tells in his writing of the terrible siege of Hesdin (1553) when the wounded were taken into the great tower and laid on a little straw, with stones for pillows and their cloaks, if they had any, used for coverlets. Linen to bind the wounds was washed daily and dried at the fire until stiff as parchment. The four "fat women" present tried to whiten the linen but there was little water and much less soap. Patients died of hunger and lack of care. Paré worked desperately day and night, with more than 200 wounded to care for. He "longed to get out of this hell and torture." The putrefying dead lay piled like faggots, no earth to cover them. The wounded soldiers were always awaiting him, they carried

him like a saint with his feet off the ground, fighting for his attention. He was unable to supply either sufficient care or the materials which he sorely needed. He advised the council to surrender as there was no hope of resisting the enemy.

At the lifting of the siege, Paré exchanged clothes with a common soldier, to prevent demands for ransom. The wounded de Martigues asked Paré to accompany and care for him. His captors sent their own physicians and surgeons to examine Martigues and they found him, though dying, well dressed and cared for. When he died, Paré was ordered to embalm him. Paré, perhaps vaingloriously, gave a discourse on anatomy while doing the embalming. The emperor's surgeon, much impressed, invited him to remain with him but he refused. He also refused the Duke of Savoy who became enraged and threatened him with the galleys. However, Monsieur de Vaudeville said if Paré would cure him of an obstinate leg ulcer he would free him. Paré succeeded and returned to Paris. There the king received him happily and assured him he had been ready to pay his ransom.

#### PRACTICED IN PARIS

Paré, after serving in the wars for 32 years, settled down in 1559 to his big practice in Paris. Much of his time was devoted to preparing his collected works. These outstanding books, as Malgaigne has pointed out, marked an epoch in surgery.<sup>5</sup> "It was the first real surgical treatise which had appeared since that of Guy de Chauliac and what a difference between the two authors—one writing at the time when the Arabian influence was predominant, the other at the epoch of the Renaissance."<sup>5</sup> Paré's works revealed the value of personal experience combined with a knowledge of the science of surgery, in contrast to the former slavish submission to traditional dogma.

During the siege of Paris by Henry IV (1590), Paré, then a man of 80 and soon to die, witnessed with horror the terror of a starving people, thousands of them reduced to eating offal and other filth and dying in the streets. The people ineffectually beseeched the Archbishop of Lyons to seek peace. Paré, encountering him, daringly demanded in the name of God that he oppose those who were preventing peace. The Archbishop, astonished at his challenge, listened and made no

(Continued on Page 142)



# It All Goes Back to Good Human Relations

## A MODERN HOSPITAL ROUND TABLE

MR. JONES: I wonder if we have done enough analyses of procedures and technics of nursing service, trying to find ways and means to save personnel time.

MISS ERICKSON: I have often wondered why we haven't done any more of that, and I have always been distressed at not getting more suggestions from nurses about what we can do. My only answer is that nursing service is a 24 hour day, seven-day week job. It never stops. You never have an end and a beginning. It goes on and on and on, and the kind of study we need is hard to do. You can always pick out one activity and say we will talk about this particular phase, only to realize that there are about 25 other different activities that tie into this. But it is encouraging to have some actual studies being done.

MR. JONES: I think the study at Massachusetts General Hospital is really going to be a milestone. We all know, too, that the American Nurses' Association has worked out a plan for studies of the nursing function in hospitals, and you remember the famous study at Bellevue Hospital by Marian Rottman and Blanche Pfefferkorn. They did a time-clock job analysis of nursing, and I feel that some of these studies may show us how to do a better job with fewer people.

MISS ERICKSON: The study at Harper Hospital should be an interesting one; they have actually reassigned duties in the hospital because of time studies.

MISS MORGAN: The matter of nurses and nursing administrators having time for ideas was discussed at a conference in St. Louis several weeks ago. They must not be so loaded with detail all the time that they can't sit back and think once in a while, to get a perspective on what is actually happening within their own service.

MISS ERICKSON: That reminds me of the hospital administrator who said she takes "dope" in the form of detailed reports that could be assigned

PERIODICALLY, The MODERN HOSPITAL invites several administrators to sit down in our editorial office and discuss their problems. A recording of the conversation is made and the transcript is published here—after editing to eliminate repetition. Hospitals of all sizes and types are represented in these discussions, but the problems selected are those that seem to occur in all kinds of hospitals.

This month the round table discusses nursing administration. Taking part in the discussion are Dorothy M. Morgan, director of nurses at the University of Chicago Clinics (550 beds); Ralph H. Hueston, administrator of Wesley Memorial Hospital, Chicago (571 beds), and Eva H. Erickson, administrator of the Galesburg Cottage Hospital at Galesburg, Ill. (135 beds). Everett W. Jones, technical adviser to The MODERN HOSPITAL, is moderator.—Ed.

to somebody else. She had no time for creative thinking, because she kills time with minor activities.

MR. JONES: As a result of the studies at Massachusetts General, they are reorganizing their head nurse function. After they get this reorganized there will be more studies. If we could only get more individual hospitals interested in study procedures!

MISS ERICKSON: I think one of the most encouraging things about the hospital picture is this beginning at-

tempt to study the big function of nursing. Many other functions have been studied, but nursing is set aside because it has so many involvements.

MISS MORGAN: What is it they say—50 per cent of every hospital budget is spent in the nursing department?

MR. JONES: That's about right. Forty to 50 per cent of the total payroll of many hospitals would be in the nursing department.

MR. HUESTON: Isn't it true that the time study program in industry has resulted in a saving in manpower, whereas time studies made in service organizations usually result in a request for additional staff to expand the services?

MR. JONES: That is true to some extent, but in the hotel field time and procedural analyses many times have shown how to do the work that three people have done with only two people.

MISS ERICKSON: In industry you count the number of nuts or bolts that you are going to put on a certain part. In nursing the human element enters in and there are disturbing factors from time to time.

MR. JONES: It is much easier to study a business or industry or organization where the product is largely



**RALPH M. HUESTON**

Administrator  
Wesley Memorial Hospital, Chicago

put out by machinery than it is to study an organization where the product is put out by hands and feet and brains. But that doesn't preclude the fact that you can study what people do, such as how far they have to walk to get things, and you can make changes in physical facilities to make it easier to render this personal service.

MISS ERICKSON: I don't know that there isn't something that needs to be studied about human contacts. I don't know that everybody understands what it is to be courteous, and how to be courteous. Not everybody comes from surroundings which make it easy for them to meet strange people and know how to open conversations and how to talk to people and how to get people to do things. I think that further study could be done on that in the hospital field—study of human relations.

MR. JONES: What I am referring to about studies of procedures and technics in hospitals is well illustrated in what they have done at the Peter Bent Brigham Hospital in Boston, introducing a revolutionary new small room where the patient is encouraged to help himself all the time.

MR. HUESTON: Patients should be encouraged to help themselves but we must explain that this "self help" is to aid in their recovery. Patients paying for private rooms may want more service, not less.

MR. JONES: Maybe we should encourage the patient. In Boston, Dr. Norbert Wilhelm really did some pioneer thinking, working with industrial engineers and architects against the initial opposition of his medical staff and many others, and he finally put those rooms in. There are still a vast number of Americans who don't have enough money to buy de luxe service, but they still want privacy. There are also a lot of Americans who like to help themselves. They would much rather be able to do these little things than to have to ring a bell and get people to come in.

MR. HUESTON: What percentage of Peter Bent Brigham's nursing service is on teaching wards?

MR. JONES: Well, I can't tell you exactly, but Peter Bent Brigham has a high percentage of teaching ward patients.

MR. HUESTON: Is it about 85 per cent?

MR. JONES: No, it isn't as high as that any more. I talked to patients personally on three different occasions



**EVA H. ERICKSON**

Administrator  
Galesburg Cottage Hospital, Galesburg, Ill.

in these new self-help units in that hospital. I talked to some patients who were in the middle income class, who expect to pay their own way and can afford to—not in a de luxe fashion, but they can afford to pay for hospital service. And I talked to some patients who had been in the open teaching wards as charity patients and were temporarily moved. So I got an interesting cross-section of opinion from patients, and I did not find one patient who wasn't tickled to death for the privacy in those new rooms and with his own ability to do some things for himself when he wanted to do it!

MISS ERICKSON: How much were those patients coached? How much were they oriented to the idea that this is something new, this is something that we are trying and want to see how it works? What will happen after it becomes an accepted pattern in that particular ward and nobody explains anything to anybody?

MR. JONES: That I cannot answer.

MR. HUESTON: If patients get the idea that we are getting them to help themselves just to save expense to the hospital, they may not like it. The demand from our patients seems to be for bigger and better rooms, although with the growth of Blue Cross we could use more minimal priced, small private rooms.

MR. JONES: In the Boston-type room, more and more people can be self-supporting and afford to pay their bills and still have decent privacy in their rooms.

MISS ERICKSON: Provided that personal services can still be had when you need them, and provided that pa-

tients aren't expected to do so much for themselves that the only person that appears is somebody to bring the medicine or the food and probably say, "What's the matter? Haven't you made your bed yet?"

MISS MORGAN: Self-help will never take the place of the personal approach.

MISS ERICKSON: Yes, and I think you must do more and more in the layout and arrangement of facilities that make a difference in care.

MISS MORGAN: It is amazing that they can go on building hospitals and making the same mistakes over and over again!

MR. JONES: Well, here is a hospital that is willing to go along with rather a radical experiment—to date with rather good results. I am citing that because we need far more of it. We need more people to question the way we have always done things.

MISS ERICKSON: That is true of nursing. Nurses have been so busy taking care of their patients according to the immediate need that they have not had time to think, "Can I do this in another way?" Of course, all our supervisors teach their students the way they were taught. That kind of thing goes on and on in nursing, and it is difficult to break into the technics and routines. It will take outside people to do it.

MR. JONES: Often, too, we are forced to ruin a good bedside nurse by moving her up to be assistant head nurse or head nurse, because that is the only way to get her some more money.

MISS MORGAN: That seems to be the case in many instances. I feel we should pay more attention financially to the excellent bedside nurse. In some hospitals they are already doing that.

MR. JONES: In other words, let's say we have a beginning, an advancing and a top salary for staff bedside nurses, and then over and above that we have a super rate for the extra good bedside nurse with a fine record and some seniority, so that she can continue to advance financially and still stay at the job she wants to do.

MR. HUESTON: I don't agree with that. If you maintain that kind of program you have an overlapping of nurses, and now that the beginning rate to attract and hold nurses has reached the point where it is, the spread between that level and higher levels is small, so you do not have

much opportunity to show credit for merit, unless you start paying at the next level of service.

**MR. JONES:** Is there enough spread between the assistant head nurse and the head nurse and the graduate staff nurse now to compensate those people for the responsible supervisory job they have? Maybe we should be paying the supervisory people rates far higher than we are.

**MISS ERICKSON:** In the small hospital the line between the supervisor and the head nurse and the assistant head nurse is not too sharp, because when the supervisor is off the head nurse moves into her shoes and when the head nurse is off the assistant head nurse walks in, and practically all three positions can be filled by the staff nurses. The supervisor doesn't have such a wide spread of responsibility in a smaller hospital as the staff nurse.

**MR. HUESTON:** On the evening and night shift, who are your supervisors?

**MR. JONES:** The senior nurse on the floor.

**MR. HUESTON:** She is taking on certain responsibilities that ordinarily belong to the head nurse, and she gets no extra money for it.

**MISS ERICKSON:** At the present time I understand nurses in the Veterans Administration hospitals are rated on the basis of their background, training and experience. Their jobs are assigned on an entirely different classification. They may have a master's degree nurse who is doing staff nursing.

**MR. JONES:** And maybe she is getting a higher rate than a head nurse who does not have the same background and the experience? Is that the point?

**MISS MORGAN:** I think we should try, if it is possible, to base salaries on the ability of the person in the particular field rather than on some organizational theory.

**MISS ERICKSON:** The salary is not the only thing that is important. In our hospital it is possible for a staff nurse who has been with the hospital for four or five years to have a higher salary than the head nurse or the supervisor who is starting. The maximum salary is reached in seven years, and most of our staff nurses have not been with us seven years. I can think of any number of instances where we have had staff nurses refuse advancement to supervisory positions, and some who have said, "Yes, I will take it for more money, but I want to go back to



**DOROTHY M. MORGAN**

Director of Nurses  
University of Chicago Clinics

staff nursing," and who have gone to the supervisor's position at an increased salary and after several weeks gone back to a staff nurse position.

**MISS MORGAN:** It's job satisfaction that counts, after all.

**MR. JONES:** On the other hand, along with job satisfaction it seems too bad that you can't reward meritorious service on the most important job in the hospital from the patient's standpoint—the bedside nurse.

**MISS ERICKSON:** How do you judge meritorious service?

**MR. JONES:** That is one of the great problems of management. Of course, unions are dead against it. But if you can judge from the comments of doctors and patients and your own observation of the kind of skilled technical care and friendly attitude some nurses exhibit that are far in advance of the ability of others, then it seems that those exceptional people should have some added reward for their superior service.

**MISS ERICKSON:** Some people are naturally much more able than others. Should you reward this particular person, on the one hand, who is naturally gracious and courteous and skilled, or the person, on the other hand, who has for two or three or four years really worked to create a good technic with patients? Those are things that come into the picture when you tell me about meritorious service. You are going to have a hard time defending your position to the whole nursing personnel in the hospital!

**MR. HUESTON:** Some places have a firm raise program which comes automatically. Then they have one,

two or three merit raises, in an established pattern. It isn't based on individual performance. It is given at the discretion of the director of nursing service.

**MISS MORGAN:** That is done on the basis of routine efficiency records and reports which are made by the head nurse.

**MR. HUESTON:** And there shouldn't be an overlapping of levels. In other words, the bedside nurse should not receive more money than the supervisor at any time.

**MISS MORGAN:** Regardless of personal excellence?

**MR. HUESTON:** That's right.

**MISS ERICKSON:** We are interested in service, and it is wise to give increases on the basis of six months, and then a year, and then another year and another year. You have a pretty difficult time setting up a salary schedule with staff nurses starting at, let's say, \$200 and maybe going up to \$250. That means that you would have to start the supervisor at \$250 and go to \$300, and what would you start your director of nursing at then?

**MISS MORGAN:** But still I think that Mr. Jones' idea of having several steps above the average for the "super" person is good.

**MISS ERICKSON:** I'm not at all opposed to the idea that a staff nurse who has been on the hospital floor for five years should be getting more money.

**MR. HUESTON:** But not for a merit program that goes above the beginning level of the next higher job!

**MISS ERICKSON:** Our staff nurse on the floor, if she has been there five years, can be making more money than the supervisor who has just been appointed to that floor.

**MISS MORGAN:** What is the reaction of the supervisor to that?

**MISS ERICKSON:** The attitude is that the other girl has earned it.

**MR. HUESTON:** The smaller the community the better that can work. The larger the community the harder it would be.

**MISS ERICKSON:** Yes, because the lines of communication are poorer in the large community. It's harder for people to understand these things.

**MR. JONES:** It is much easier for you to explain the situation to your 175 people than it is for Mr. Hueston in a 600 or 700 bed institution with 1000 employees.

**MISS ERICKSON:** Is it at all surprising?  
(Continued on Page 144)

## BRITH ROOMS have public relations value, too

ACCORDING to recent statistics,\* approximately 26,700,000 persons reside in the 25 largest cities of the United States. This population range is drawn from Portland, Ore., supporting a census of about 305,000, to the Greater New York metropolitan area, which supports between 7,000,000 and 8,000,000 persons.

Within the same range, it is interesting to note that approximately 3,600,000 Jewish people reside in the same areas, or percentage-wise, about 13.4 per cent of the population of those areas. Since there are about 4,500,000 Jews in the United States, these areas hold some 80 per cent of the entire Jewish population, thus supporting the fact that there is a tendency for the Jewish people to establish themselves in the larger urban areas.

These questions should now be considered: "What are the responsibilities of the hospitals in these urban areas to the Jewish population?" "How can

\*American Jewish Year Book, American Jewish Committee, 51:71 1950.

these hospitals act toward promoting the welfare of this group and, at the same time, strengthen their public relations programs?"

Hospitals of today have recognized this need and are conducting many varied programs in this field of endeavor. This article is concerned with only one phase of this project: how hospital administrators can recognize religious needs and provide added service to the community.

According to the Jewish law, a Brith Milah (circumcision) ceremony must be performed on every male offspring on the eighth day following birth. It is the usual custom that this procedure be performed by a mohel (a rabbi who has received special training in performing circumcisions). Because the

maximum length of stay of a maternity patient in a hospital is about eight or nine days, circumcision ceremonies are usually performed just prior to the mother's discharge from the hospital.

Here at the Jewish Hospital of Brooklyn, and at many other Jewish hospitals throughout the country, administrators and boards of trustees have already recognized the need for special facilities in the performance of this ceremony so that it may parallel the general standards of medical care provided to the community. The answer can be found in brith rooms.

We have set up in the obstetrical division of our hospital two separate circumcision rooms, commonly known as brith rooms (Fig. 1). These brith rooms consist of circumcision rooms and party rooms that are separated from each other by glass windows similar to those used in most nurseries (Fig. 2). In this manner, we are able to permit visitors to witness the ceremony and at the same time maintain the sterility of the circumcision rooms.

Also included in the suite of rooms is a utility room in which supplies are kept, and a comfortable waiting room located just outside of the foyer.

The sterile technic is maintained in the circumcision rooms much the same as it would be in the operating rooms. Every precaution is taken to ensure the safety of the newborn. However, in one phase of the ceremony, it is required that the grandfather of the infant as well as the godparents enter the circumcision room. Prophylactic measures call for these three to be clad in gown, cap and mask, and they are briefed by the mohel beforehand as to the part they are to play in the ceremony.

Figure 1 outlines the most convenient layout and labels all necessary items in the circumcision rooms. It is the responsibility of the circumcision nurse, a graduate with pediatric training, to

### MANUEL J. SEGALL

Administrative Assistant, Mount Zion Hospital, San Francisco  
Formerly, Administrative Assistant, Jewish Hospital, Brooklyn, N.Y.

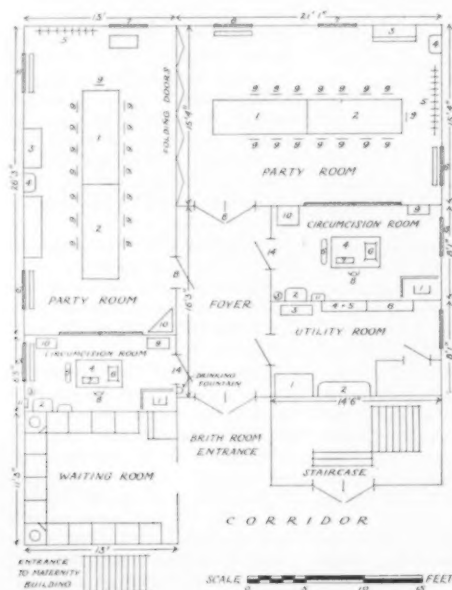


Fig. 1. Floor plan of brith rooms.

#### CIRCUMCISION ROOMS

1. Honorary chair
2. Scrub sink
3. Receptacle
4. Circumcision table
5. Hamper
6. Pillow
7. Sterile pack
8. Nurse's chair
9. Sterile linen cabinet
10. Utility table
11. Utility ledge
12. Soap dispenser
13. Window
14. Entrance from foyer

#### PARTY ROOMS

1. Party table
2. Party table
3. Crystal cabinet
4. Wash basin
5. Clothes rack
6. Windows
7. Emergency exit
8. Entrance from foyer
9. Chairs accommodating 18 persons
10. China cabinet

#### UTILITY ROOM

1. Cabinet for glass and silverware
2. Sink for soiled dishes
3. Food preparation table
4. Towel cabinet
5. Sterile pack materials cabinet
6. Paper serviceware cabinet

see that everything is prepared and available for use by the mohel.

The party rooms that adjoin the circumcision rooms provide space, as mentioned before, for the visitors to witness the ceremony. Tables are set up so that the traditional feast may take place following the ceremony. Such a feast today consists of the serving of appropriate beverages and cake and is symbolic of the great feasts that were held in biblical times to celebrate the occasion. All food is provided by the family, and accessories, including linen, paper service, glassware and silverware, are provided by the hospital.

Responsibility for the efficient operation of the brith rooms is centered in the assistant housekeeper, who also acts as hostess. Her duties consist of scheduling the brith ceremonies, providing the necessary items to make the celebration a success, and supervising the daily upkeep of the rooms. She is assisted by a hospital aide and a housekeeping porter. An integral part of her responsibility is one of public relations, the importance of which cannot be overemphasized. She is the individual who meets the public and creates lasting impressions, many of which may at a future time serve as a basis for public opinion. Her job is as important as that of the director of public relations and therefore the hostess must be chosen with care (Fig. 3).

Responsibility for the performance of the circumcision lies with the mohel, who is responsible not only to the family of the infant, but also to the administration of the hospital. There are five mohelim on the hospital staff performing the service, two of whom are on service at any one time. Rotations of the schedule are made semimonthly in order that all may participate equally. Any changes in the schedule must carry the approval of the hospital administration.

Brith ceremonies are scheduled for the morning hours and usually extend through the early afternoon. Because of the double arrangement it is possible to schedule brith ceremonies every half hour, so that as one set of rooms is being used, the other is being prepared for use. Planning ahead for eight days in advance makes the task simple, because reservations must be made by the father of the infant immediately following the birth. By considering all male births on a certain day, we know the maximum number of ceremonies to be done eight days hence.

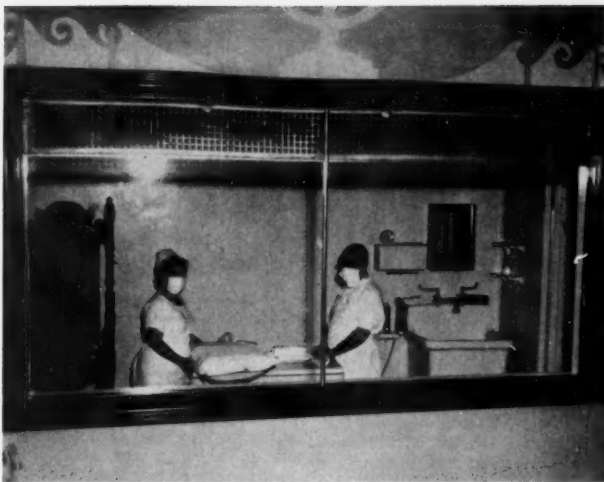


Fig. 2. Circumcision rooms and party rooms are separated from each other by glass windows so that visitors can witness the ceremony without entering the circumcision rooms.

The brith room services provided by our hospital have consistently been popular with the community for the past decade or so, since its inception. It

Tables are set up in the party room so that the traditional feast may take place following the ceremony. The assistant housekeeper is in charge and acts as official hostess.

has made many friends for the hospital and at the same time has provided a definite service to the community. When an obstetrical patient comes into the hospital to have her baby, she, no doubt, has many things on her mind. Because we are able to provide her son with a ritual circumcision procedure almost automatically, we are saving her worry and anxiety, thus definitely aiding her convalescence. A hospital is primarily a service organization providing ancillary services that go a long way to establish good will and sincere friendship between the community and the hospital.





## Small Hospital Forum

### It Costs Less to Know Your Costs

*a punch card cost accounting system is available  
and feasible for small hospitals*

#### CAPT. REXFORD A. HINEY

Office of the Quartermaster General  
Department of the Army  
Washington, D. C.

A FEW years ago a new administrator took charge of a small hospital in the District of Columbia. After a few weeks of studying the activities and procedures of the hospital, he became aware that there was no accurate method of determining the costs of operating the various departments and services. The bookkeeping system did not provide for any cost analysis, thus making it impossible to determine the cost of operating such departments as the laboratory, outpatient clinic, x-ray clinic and operating rooms. This administrator knew that money was coming in and was being paid out and that an accurate record of these financial transactions was maintained but the accounting system did not provide for comprehensive cost studies.

#### HAD TO SUBSTANTIATE CHARGES

It was imperative that the administrator know the operating costs since he was being called upon constantly to substantiate the hospital charges for private room service, ward service, laboratory service, and so on. Private individuals and organizations, such as the Community Chest and other welfare groups which provide monies for the hospitalization of indigent patients, desired to know how the charge per hospital day was computed. Under the existing accounting procedures, it was exceedingly difficult to explain and justify.

This administrator was employed previously at a much larger hospital which had a complete cost accounting system accomplished on electric punch card accounting machines. He desired to have the same complete system in this smaller hospital but was afraid that the cost was prohibitive since he was of the opinion that punch card

systems were only profitable on large volume operations. A thorough study of the problem indicated that a method using punch cards was available through the services of a service bureau operated by a manufacturer and lessor of electric accounting machines. This method incorporated a procedure which took advantage of the versatile and flexible electric accounting machines, and accomplished the same result as the cost accounting procedure in the larger hospital except that it operates on a smaller scale. The result was an almost identical procedure at a nominal cost to the smaller hospital.

The most important step in developing a cost accounting system is the establishment of a complete chart of cost accounts. A departmental segregation of costs is necessary so the chart must have accounts set up for each segment of the organization. In addition to departmental costs, the chart must include accounts to segregate costs by the various supply and service activities. A careful analysis of the organization structure and of the important expense items resulted

in a satisfactory chart of cost accounts for this hospital.

Numerical codes must be assigned to these accounts to complete the chart and make it ready for use in the cost accounting procedures. A block of numbers is usually assigned to each major classification. In our chart the 100 series identifies administration costs, the 200 series identifies the costs of dietetics, and so forth. Within each block of the code, numbers are assigned to the minor units. In the administration major group (100 series) are the executive office—Code 101, post office—Code 102, business office—Code 103.

#### HOW IT WAS DEVELOPED

It is not necessary in this discussion to go into the ramifications of procedural development since they are many, varied and often complicated. In this particular case, this hospital administrator, working with representatives of the service bureau, developed the cost accounting procedure and placed it in operation. This was accomplished by, first, outlining the objectives of the application; second, systematically designing the procedure, working with the chart of accounts and the final objectives, and, third, integrating the procedure into the hospital operations.

One of the inherent advantages of using electric accounting machines is the flexibility through the use of a uniform sized unit record—a punch card. The fact that each card represents and has recorded in it one transaction or one posting entry, and the fact that these cards are of the same size, makes it possible to arrange and rearrange these unit transactions by machinery in any desired sequence. Once the cards have been arranged in



the proper sequence, printed accurate accounting reports may be prepared automatically in an unbelievably short time on an electric accounting machine.

The unit record or punch card designed for this hospital's use is entitled "Hospital Stores Requisition." The primary purpose of the card is for requisitioning supplies and for recording the cost of those supplies. In addition, it is used to record the cost of personal services, maintenance and miscellaneous expenses.

To execute the requisition punch card properly, the description and quantity of the stores to be requisitioned or ordered must be written on the left part of the card. The other essential elements of a proper requisition must also be added, such as department, date, authorizing signature and approving signature. On the right portions of the card are recorded the department to be charged, the classification of those charges, and the total charge.

#### USES SPECIAL PENCIL

The recording on the right part of the card is in the form of a series of marks made with a special pencil with lead of high carbon content. On the right portion of the card are the marks that represent Department "409," classification "1223" and the amount "\$12.35." Since these pencil marks are electronically sensed by the electric punch card equipment, this method of recording data is known as "mark sensing."

The "mark sensing" requisition cards are made up in pads of 50 cards each with a tissue carbon copy between each two cards. These pads are furnished to each unit that orders supplies, i.e. ward, operating room, pharmacy. Employees of each unit fill out the left part of the requisition and "mark sense" the department and classification sections of the right portion each time supplies are ordered. The tissue copy which has the same data recorded by carbon paper, is retained in the unit as the record of supplies on order. As the requisition is filled by the storekeeper, the cost amount of the requisition is "mark sensed" on the extreme right portion of the card. Thus the procedure for requisitioning supplies and for recording supply costs by using the same unit record—the punched requisition card—is completed.

Each maintenance job performed in

The primary purpose of this "Hospital Stores Requisition" card is to requisition supplies and record the cost. It is also used to record the cost of personal services, maintenance and miscellaneous expenses.

the hospital, both on medical equipment and on the buildings, is recorded on these cards by writing the name of the job on the left of the requisition card and "mark sensing" the cost accounting data on the right portion of the card. Personnel costs are recorded by completing a card for each employee every pay period. Each card is posted with gross pay, department and classification "mark sensed" in the proper sections. Overhead costs and miscellaneous expenses are also recorded on these cards to provide a punch card file complete with all costs to be charged during the month.

At the end of the month the complete cost accounting punch card file is transmitted to the local electric accounting machine service bureau for the mechanical processing. Personnel thoroughly skilled in the mechanics of electric punch card accounting processes the cards through the various operations necessary to produce the monthly statements of cost. Briefly the steps are as follows:

1. The pencil marks are electronically sensed and punched in the cards.
2. The cards are arranged mechanically in sequence by classification.
3. The monthly statement of costs by classification is prepared on the electric accounting machine. This report by classification shows the costs charged to each category of personal service, equipment, supplies and services other than personnel.
4. The cards are further arranged by department which produces a sequence by department and within department, by classification.
5. The monthly statement of costs by department by classification is prepared. This report by department by classification shows the cost charged

to each classification category and the total cost of each organizational unit or department.

The service bureau completes the processing of cards and the preparing of the statements in approximately two days after receiving the hospital cost card file. The reports are immediately transmitted to the hospital administrator.

The administrator has a report on his desk approximately five days after the close of each month with the cost of each department, personal service and supply service. He knows how much money each unit in the hospital required for functioning. Cost comparisons between one month and another can be made for any number of months with practically no effort. Analysis of these comparative statements indicates trends and discrepancies in cost, pinpoints out-of-line costs, and indicates problem areas that need particular attention.

#### MAKES USE OF MODERN TOOL

The costs of the various units can be applied against the number of patients served to obtain a cost per procedure or treatment in the laboratory or x-ray departments and the cost per hospital day of patient care in rooms or wards. Each cost quoted to individuals or organizations can be substantiated by accurate and sound cost figures—not by guesses. The administrator of this hospital has taken advantage of a modern management tool—an effective tool which produces current facts and figures to aid in operating an efficient hospital.

The cost of punch card service per patient day at this hospital is \$0.008, excluding cost of requisition cards which is offset by the cost of the requisition form formerly used.

## About People

### Administrators

**Charles K. Le Vine**, since 1947 superintendent of the Sanatorium of the Jewish Consumptives' Relief Society at Spivak, Colo., has been named administrator of Beth Israel Hospital, Denver. His new duties will include administration of the Beth Israel Hospital as well as supervision of the Beth Israel Old Folks Home. Mr. Le Vine is chairman of the public education committee of the Colorado Hospital Association, a member of the board of trustees of the Colorado Tuberculosis Association and a past president of the Denver Area Sanatorium Council. He also is a personal member of the American Hospital Association and a nominee of the American College of Hospital Administrators.



C. K. Le Vine

**Dr. David Ross**, a psychiatrist and formerly head of the Seton Institute of Baltimore, has been appointed medical director of the National Hospital for Speech Disorders, New York City, succeeding the late **Dr. James S. Greene**, internationally known speech specialist, who founded the hospital and served as its head until his death in 1950. From 1946 to 1948 Dr. Ross was medical superintendent of the Argyll and Bute Mental Hospital in Scotland and while in that post introduced outpatient treatment to the West Highlands.

**Morris B. Squire** has been named executive director of the Northwest Home for the Aged in Chicago. He was formerly associated with the Orthodox Jewish Home for the Aged and the Jewish Community Centers of Chicago.

**Russell N. Tucker** has resigned as administrator of Hilo Memorial Hospital, Hilo, T.H., to accept the post of administrator of the Kapiolani Maternity and Gynecological Hospital in Honolulu. In the United States Mr. Tucker was at one time associated with the Oklahoma General Hospital and Mercy Hospital, Oklahoma City, Okla., as assistant administrator and assistant business manager, respectively.

**Dr. I. S. Ravdin** has been named temporary vice president of medical affairs at the University of Pennsylvania, succeeding **Dr. Robin C. Buerki**, whose appointment as executive director of the Henry Ford Hospital in Detroit was announced in the September issue of this magazine. **Dr. John McK. Mitchell**, dean of the university's medical school, was named special assistant to Dr. Ravdin.

**John L. Turnbull Jr.** is now assistant director of Lankenau Hospital, Philadelphia, succeeding **Donald S. Grant**, a reserve officer recently recalled to military service.

**Dr. Carl A. Neves**, who has retired as manager of the Veterans Administration Center, Hot Springs, S.D., has as his successor **Dr. Francis W. Ogg**, the former chief of professional services at the center. Dr. Ogg formerly served as chief of professional services at V.A. hospitals in East Branch, Me., and Bath, N.Y.

**Rex Madden** has been named business manager of the Western Oklahoma State Hospital at Clinton, Okla., succeeding **C. A. Wheeler**.

**William Burge**, formerly administrator of the Lillian M. Hudspeth Memorial Hospital at Sonora, Tex., has been appointed administrator of the new hospital at Marysville, Ohio, which has tentatively been named Union County Memorial Hospital.

**Margaret Wilson, R.N.**, has resigned as superintendent of the Jersey Shore Hospital, Jersey Shore, Pa., a post she has held for nine years. Miss Wilson is a member of the American Nurses' Association and the Pennsylvania Hospital Association.

**Harold T. Norman** has been named assistant administrator of Children's Hospital of the East Bay, Oakland, Calif., it was announced recently by the board of directors. Mr. Norman has been with the hospital two years as business manager.



H. T. Norman

**Duane E. Johnson**, who has been assistant administrator of the Latter-Day Saints Hospital at Salt Lake City for the past year, has been appointed administrator of the Audubon County Memorial Hospital, Audubon, Iowa, which is still under construction.

**Marvin J. Lawrence** has been appointed assistant to **Dr. David H. Ross**, executive director of the Jewish Hospital Association in Cincinnati. Mr. Lawrence received a master of science degree in hospital administration from Columbia University and for a year prior to his current appointment he served as administrative resident at the Jewish Hospital Association. He also has been a teacher in the Detroit public schools and a psychologist with the Veterans Administration. The new assistant is a member of the American Hospital Association and the American Public Health Association.



M. J. Lawrence

**Dr. George O'Hanlon** retired on October 1 as medical director of the Jersey City Medical Center, Jersey City, N.J. His successor is **Dr. J. James Smith**, who became medical director of the city division of the medical center last spring. Dr. O'Hanlon, who held the Jersey City post since 1925, is now planning consultant for McKinley Hospital, Trenton, N.J. He is a former president of both the American Hospital Association and the New Jersey Hospital Association.

**John D. Taube**, former administrator of the Northern Pacific Beneficial Association Hospitals at Tacoma, Wash., assumed his new post as administrator of the Kennewick Memorial Hospital, Kennewick, Wash., November 1. The Kennewick Hospital is now in the process of construction and will open April 1, 1952. Mr. Taube is a 1950 graduate of the school of hospital administration at the University of Minnesota.

**Douglas V. Martin Jr.** has assumed his new duties as director of development. (Continued on Page 170)

# How to *Control* the Sterile field



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# Industry Gets Into the Act

*to make the fund campaign a success*

ONCE upon a time, long long ago, hospitals had few financing problems. They ran up operating losses year after year, and each year rich merchant or industrial princes came by and relieved the bookkeepers' distress.

But the hospitals did not live happily—at least, not ever after. Beginning 20 years ago princes seeking hospitals in distress to rescue seemed to sally forth less regularly and those who did—while just as willing to help—weren't as rich as they once had been. The old orders were yielding yet defenders of the hospital system to take their place had not yet appeared.

Our hospitals are still in financial distress, and the sources of funds to

offset operating losses still not definite. We live in a never-never land. In our economy corporate financial difficulty—operating at a loss—is invariably an unhealthy sign. Paradoxically, in our hospitals the opposite may be true, with the size of the operating loss often the most reliable indication of the extent that a hospital is meeting its community responsibilities. The difficulty of financing is no less distressing to trustees despite knowledge that a good job is being done. Virtu-

ally every source of funds has been tapped for maintenance and construction funds, yet with tax programs becoming more comprehensive and rates higher, no satisfactory solution has been found. But recently, even as the situation has become more acute, statements from public figures with widely disparate interests have pointed a way toward solution.

Alfred P. Sloan, writing in a recent issue of *Collier's*, stressed the dire financial situation of our colleges and other free institutions, and called upon American business to rally to their help. The tax laws, Mr. Sloan said, make possible from monies that otherwise would go to the government in the form of taxes substantial contributions at little expense to the contributing organizations. In this way the tax laws actually tend to stimulate giving. Mr. Sloan further declared that such gifts are a matter of enlightened self-interest, for since our free institutions are essential to preservation of our free enterprise system they must be supported, while any failure of American enterprise to support them

### EDWARD E. JAMES

Hospital Director  
North Shore Hospital Fund, Inc.  
Great Neck, Long Island, N.Y.



Jinx McCrary sells the first membership in the industry fund to an aircraft employee.





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plays directly into the hands of those groups within the economy and the government who wish to see the hospitals become agents of special interest groups.

Shortly after Mr. Sloan's challenging appeal, tax expert Beardsley Ruml in a news story datelined Washington stated that last year only one-fourth of the monies that might be given at little expense under the tax laws to hospitals, colleges and similar tax-exempt institutions had been given. Pointing to the great potential support possible under the tax laws, Mr. Ruml—famous advocate of pay-as-you-go taxation—implied that American business was missing the boat on its last great chance to save the bulwarks of the system in which it has prospered. More recently *Fortune* magazine has discussed the responsibility of American business for support of free institutions.

#### LAW FAVOR GIVING

Such tax experts as J. K. Lasser have long urged taking advantage of this seeming quirk of the tax laws that favors giving at what appears to be government expense, and in innumerable instances corporations by giving have taken advantage of the situation. As a recent *Kiplinger Tax Letter* brought out, gifts need not be in cash, but can be in the form of securities, land or other property. Oftener than not, however, support has been spotty and inadequate to do the job. On a local level there has been inconsistent performance. One or two companies might give generously while others refused even a token gift. There has been no model performance to set the pattern and the pace for the rest of the country.

Last summer on Long Island an organization was formed to provide funds for hospital construction that seems well on its way to blazing a trail for the nation to follow. The island—Nassau and Suffolk counties, with a combined population of more than 1,000,000—is the country's fastest growing area. It is also a highly strategic industrial section. Many essential industries are already located there, with industrialization of wide areas of what was once called "Pleasure Island" proceeding at a rate that far outstrips the available labor supply. Combined population growth and industrial mushrooming has brought with it many problems. Several years ago the most pressing shortage was

of housing units, eased through building of Levittown and hundreds of other developments. Now the most acute need is for hospital beds.

In June Hill-Burton funds were hoped for to improve the present island ratio of one bed per 731 persons, but when New York State priorities on federal funds were announced, Nassau County—where need is greater than in neighboring Suffolk—was rated too low to be in the money. Stung by the refusal at this time of federal funds, Leon A. Swirbul, president of Grumman Aircraft and chairman of the Regional Hospital Planning Commission, developed a plan to help the area help itself by tapping support of industry that until this time had not given significantly. As in other local situations, there were reasons why industry had not helped the hospitals more; basically each was new to the other's demands and problems. The abrupt industrial growth of the island had left little time for industrialists to examine their community relations, much less to improve them; and the hospitals engulfed by the population tidal wave had little opportunity to shape services to meet the needs of the new neighbors. A plan like Mr. Swirbul's to gain industrial support had never been tried anywhere in the country, yet he was sure it would work.

Mr. Swirbul believes that an unfettered medical care system is a prime requisite to a free economy and that in turn hospitals are the keystone of a progressive health program. The Grumman executive's problem was to sell his ideas to other industrial groups and to channel group energies into activities yielding funds for hospital construction. Complicating the situation were fund-raising drives of four hospitals. Money had to come from new sources, not from groups contributing to the hospitals' own fund drives. The program also had to be planned around a permanent organization, for a one-year or "one-shot" approach could not possibly raise the money needed for expansion of even one hospital.

Mr. Swirbul's first move was to discuss the common need for hospital expansion with all groups: labor leaders, industrialists, hospital authorities, public officials. All realized how acute the problem was. Each agreed to give serious attention to any approach that seemed to hold promise of raising substantial funds from new sources.

Industry—corporations and workers—seemed to be both the largest relatively untapped source and the element most affected by the bed shortage.

The search for co-workers led Mr. Swirbul to Tex McCrary, campaign chairman and trustee of the North Shore Hospital building fund, who had produced a gigantic "Star Night" the previous year as a benefit for the North Shore Hospital. Mr. McCrary agreed to promote the Star Night for the organization Mr. Swirbul planned, so it might benefit all Long Island hospitals instead of merely one. The Star Night provided three things: a drawing card to employ participation, an event with demonstrated potential as a fund-raising device, and a time table against which to work, for the show had to be staged outdoors before cold weather set in. The importance of Star Night as a device to encourage employee participation could not be overemphasized, Mr. Swirbul found. Employees often halfheartedly supported drives of various sorts, but no previous appeal gave the promise of top entertainment as a reward for support that the industry fund promised. The Star Night was the key to the success of the entire venture.

#### HOW IT WAS ORGANIZED

Second phase was setting up an organization. A breakfast for leaders was held, and an organization—the Long Island Industry Fund for Hospital Construction—was created. Fund trustees represent all companies and groups in the industrial hierarchy.\*

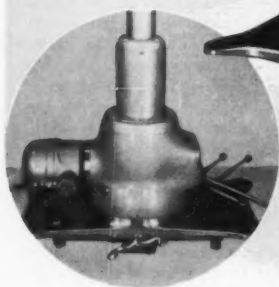
The organization emerged as a tax-exempt corporation; memberships admit cardholders and one guest to certain fund activities and make possible

\*Among the officers are: Leon A. Swirbul of Grumman Aircraft Engineering Corporation, president; Robert L. Forrester of the A.F.L. Building Trades Council, Nassau-Suffolk, secretary; Robert L. Conlin of Doubleday & Company, treasurer. Vice presidents include: Preston L. Bassett, president of Sperry Gyroscope Corporation; George F. Chapline, executive vice president of Fairchild Engine & Airplane Corporation; Fred Gibson, president of L. I. Home Builders Institute; Charles Kerrigan, head of Nassau-Suffolk C.I.O. Council; Mundy I. Peale, president of Republic Aviation Corporation; Joseph Ridder, chairman of the board of the Arma Corporation. Also associated are: Tex McCrary, "Hospital Star Night" producer; Paul B. Townsend of the North Shore Hospital campaign staff; organization director, J. B. Rettigata of Grumman Aircraft Engineering Corporation, public information director; A. C. Barnett of the South Nassau Communities Hospital campaign staff, membership director; and Henry Root Stern Jr., legal counsel.

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HOSPITAL...**



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**UNIVERSAL  
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required position. Table tilts 45° head low. Patients relax on resilient sponge rubber cushions.

For an explosion-proof operating table, the Type "2" Table can be supplied with an explosion-proof base, conductive rubber rollers, brakes and static-conductive rubber slip covers. For maximum safety, the Ritter explosion-proof motor has all electrical mechanism, including mercury switch enclosed in an explosion-proof case. Safety features have been tested and approved by the Underwriters' Laboratories, Inc.

To assist in operative procedures, optional equipment, at additional cost, includes arm board support, ether screen, shoulder supports, wrist restraints, knee crutch set, and strap hanger crutch set.

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participation in various give-away programs. Tentative agreement also has been reached on a formula for distribution of funds among hospitals with building programs.

Having won the support of key people, Mr. Swirbul then set about broadening that support. A dinner meeting in early September attended by 200 leaders of American business with Arthur Godfrey as master of ceremonies won more new friends for the program. In August an "Industry Fund Caravan" featuring such personalities as heavyweight champion Joe Walcott,

Tex and Jinx McCrary, Ray Heather-ton, Eloise MacElhone and Captain Video toured industrial plants rallying workers' support of the industry fund. Throughout this phase, Star Night was widely advertised. When the membership campaign ended, nearly \$100,000 in memberships had been sold. Many companies had 100 per cent employee participation.

The Star Night, held September 16 at Belmont Raceway, was a tremendous success. More than 32,000 people turned out to watch 38 stars, top names of TV, screen, stage and radio

perform, backed by a production crew of 400 and an airlift of light planes and helicopters. Spectacular shows of this sort have another use in addition to providing good entertainment. They are unmatched attention-getters, with an area impact that focuses attention of all elements of the community on the project. And, like the plant membership rallies, they improve employee relations as employees and supervisors have a good time together.

The membership phase over, the industry fund is now in the corporation gift period. Already some companies acknowledging the need for adequate hospital care for their employees have announced gifts. Among gifts received are \$10,000 from a publishing company, \$60,000 from an aircraft company, and \$1500 from a tool manufacturer employing only 20 people. The corporation gift period is really an educational phase. Contributions must be set before the tax year ends. To raise the fund total to \$250,000 this year probably will not be difficult, and perhaps next year's quarter-million can be raised too. But to fail to make industry realize that it is not giving a gift in supporting hospitals but rather investing in improved health for its workers and improved relations with its communities would be tragic. Like any good investment, this one will show a return.

At this time sustained success for the Long Island Industry Fund for Hospital Construction seems assured. It has tapped new sources of financial support in the search for capital for speedy hospital construction.

Perhaps the place of the industry fund is best summed up in the words of Robert Conlin, treasurer of the industry fund and treasurer of Double-day & Company: "If business cannot support hospitals where obvious health needs are being met, then it cannot be expected to support other institutions like universities that deal only in abstractions. In any case, if this potential new source of support is not developed, nationalization of all free institutions inevitably will occur and might even be followed by the nationalization of industry itself.

"The most important thing about the success of the Long Island industry fund from a national standpoint is that its progress to date is based on mature realization by industrialists that hospitals and industry are an inseparable, interdependent team in our free economy."

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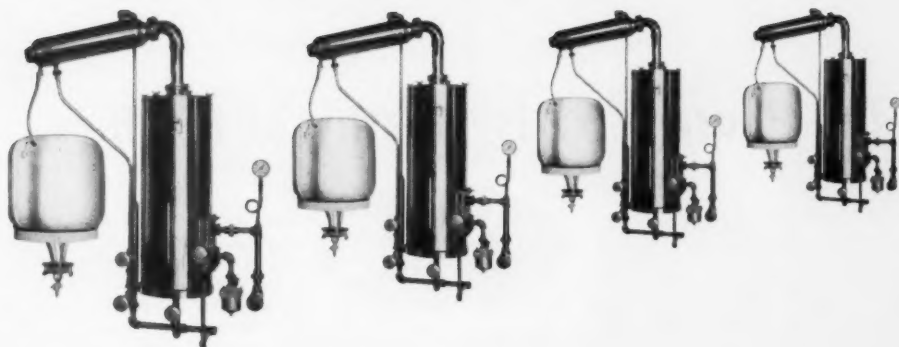
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## The Pharmacist Is Worthy of His Hire

THE goal of every department of the hospital is to furnish the patient with the best of service at the most economical cost. The pharmacy is not an exception inasmuch as it is one of the most extensively used therapeutic facilities of the hospital.

Approximately 5 per cent of the total annual expenditures of hospitals go for pharmaceutical services. This figure (approximately \$125,000,000) alone emphasizes the need for a careful analysis by the administrator to foster economies. That a hospital pharmacy with a well qualified hospital pharmacist in charge is a necessity has been accepted by the larger hospitals. Small hospitals have not all taken this position, largely because of the fear of increasing their operating deficits.

### EFFICIENCY IS LOWERED

Hospitals which fail to employ a pharmacist with proper training, experience and talent, however, are seriously lowering the efficiency of their services and operations. A well organized pharmacy will function efficiently in its own right, and also contribute to the whole integrated hospital organization. Employment of a full-time pharmacist even in a hospital of moderate size, far from being an exorbitant expense, will more than pay for itself through collateral savings.

*The duties of a hospital pharmacist.* The scope of the hospital pharmacist's duties has been defined in "Minimum Standards for Hospital Pharmacists" of the American Society of Hospital Pharmacists and American Pharmaceutical Association. Most of these duties are known to the administrator, but often he fails to recognize the extent or value of the professional services which the pharmacist renders to the hospital.

**ALEX M. MILNE**  
Division of Hospital Facilities  
Public Health Service  
Washington, D.C.

*Law.* The standard of care required for the operation of a hospital pharmacy from a legal point of view must be considered. "Law of Hospitals, Physicians and Patient" by Hayt and Hayt devotes chapters 18 and 19, "Drugs and Prescriptions and Narcotics" to the activity. On page 347 it is pointed out: "The hospital administrator should investigate the qualifications of the pharmacist for there must be no negligence in the selection." On page 348: "All states require that the pharmacist be registered by the state board either after examination or by reciprocity and if the pharmacist is unregistered the hospital may find itself at a disadvantage if a claim for damage is made against the hospital and pharmacist."

How much more is this true if the hospital delegates its pharmaceutical service activities to a lay person, nurse or physician, none of whom is qualified by training or law to practice pharmacy. Certain states in recent years have enacted legislation or amended the state pharmacy laws, making it mandatory for hospitals to employ a pharmacist.

Most important of all is the service to the patient. He is dependent on the hospital and expects medication dispensed by a qualified person. The registered hospital pharmacist fulfills these expectations in providing medications meeting the highest standards. They are available quickly and at a minimum of expense to the patient.

The pharmacist renders a professional service to the medical staff. The advantages of frequent contacts be-

tween the staff and the pharmacist are important. He is a source of information on the relative merits of different brands of the same basic drug and can advise on the dosage and strength of the innumerable new preparations being manufactured today. The physician's armamentarium has increased tremendously in the last decade. Contact with the staff also results in suggestions to the pharmacist whereby he can improve the pharmaceutical service.

### NOT THE NURSE'S JOB

The pharmacist renders a professional service to the nurse. The tendency to assign to nurses the responsibility of dispensing items that only an experienced pharmacist should issue is avoided. The issuance and control of narcotics and barbiturates, the preparation of solutions of various percentage strengths, proper care of perishable items, labeling and filling of stock bottles and other containers for the various nursing units are duties most accurately and safely performed only by the pharmacist who is directly responsible to the hospital. The pharmacist will contribute largely to the education of nurses in the uses, actions and dosage of drugs. He keeps a file of the literature on new drugs and informs the nurses by bulletins of the advances in therapeutics. The pharmacist is frequently consulted by nurses on dilutions and fractional doses of prescribed medications. Preparing dilutions of penicillin, streptomycin and narcotics in the pharmacy are time and money saving methods.

There is saving in time and effort of the personnel, which, when there is no pharmacist, must handle the ordering and receiving of items obtained from the local drug store and issue, control and replenish floor drug

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## NAME OF NARCOTIC

DATE	TIME	NURSE	REMARKS

Fig. 1. Narcotic—Perpetual Inventory Form

supplies. Someone must purchase drug supplies and if this is done by an inexperienced individual the drug costs for the care of patients can be excessive.

Since everybody's business is nobody's business, the concentration of these various duties under one department head is an economy. These are all nonincome producing but valuable assets of the hospital pharmacist. However, the salary of the pharmacist must be paid. The problem to the hospital, therefore, is: How can the pharmacist render this type of service and not show a loss for his department? Actually, a well organized pharmacy has proved to be revenue producing even in small hospitals. The medication cost per patient day is reduced by proper management. The charges for medication to pay patients are established on a businesslike basis, usually "cost plus." An exception to this may be made on the "ordinary drugs" stocked in the floor medicine cabinets. These drugs are often dispensed without charge to the patient. This avoids irritating and time consuming nuisance charges.

#### ORGANIZATION

Reducing medication cost per patient day requires good organization and the cooperation of the administrator. Each procedure developed can effect economies to the hospital both in time and in money.

**Administration.** In order to systematize his work, the pharmacist's daily work schedule is coordinated with the activities of the other departments of the hospital. The systematic collection and delivery of floor baskets to the nursing units saves nurses' time by reducing requisitioning to a minimum, making frequent trips to the pharmacy unnecessary, and avoiding delays in the daily nursing program.

A requisition system is essential in saving the time of all departments served by the pharmacy. A requisition

form listing the items and sizes of drugs stocked in the floor medicine cabinets will simplify ordering by the nurse and pricing by the pharmacist for charge purposes. With the head nurse's cooperation, the requisition for special medication should contain all needed information whether written by a physician, intern or supervisor: date, floor and room number, patient's initials, whether medication is for oral or hypodermic use when both are available, size of dose and frequency of administration.

The pharmacy also coordinates its services with the business office in pricing and promptly submitting all charges and credits.

**Charges for drugs.** Methods of distributing and charging for drugs should be considered under drug policy, and an approved unit-cost schedule should be developed. Charges to patients differ between hospitals, with several methods in general use.

1. On an all-inclusive rate: Almost every preparation in the hospital formulary is issued without charge.

2. On a part-inclusive rate: Certain specific formulary items will be floor stock, and administered to the patient without charge. Others will be charged to the patient on the basis of cost plus a given percentage. There are several formulas, varying from 50 per cent to 100 per cent, but operating costs should be covered, plus a nominal profit.

#### SUPERVISION AND CONTROL

Drug stocks in nursing units should be standardized and kept at a useful minimum and should be inspected by the pharmacist, accompanied by the nursing supervisor, at least monthly. Old and deteriorated medication is picked up. Unopened original packages may be returnable to the vendor for credit. Containers and labels in poor condition are returned to the pharmacy. Excess stock is often found. The drug stock kept in the medicine

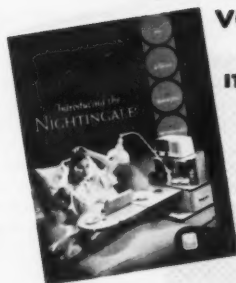
cabinets of the nursing units should be in containers of standard size. The size varies with the size and number of tablets or capsules, or volume of liquid required for a minimal supply. Some hospital pharmacies work with a two-unit container system which provides for a full container remaining on the floor while an empty container is in the pharmacy being refilled. This eliminates the dangerous practice of placing the few remaining tablets or cc.'s of a liquid in a medicine glass to satisfy floor needs while the sole container is at the pharmacy for refilling. Each container carries a label with a protective coating. The label shows the station of the container, e.g. "O.B.," the name of the drug or preparation, the unit strength and capacity of the container.

**Drugs for emergencies, including antidotes.** Emergency needs can be predetermined fairly accurately after a study by the pharmacist, and an emergency cabinet stocked with most of those drugs can be kept ready for use. A list of antidotes approved by the staff should also be stocked in the emergency room and kept in proper condition by the pharmacist.

**Narcotic control.** There is no problem in applying for a federal narcotic permit or ordering on the prescribed federal narcotic order form. The control and distribution, however, is one of the important duties of the pharmacist. He is familiar with the Harrison Narcotic Law and its requirements. A perpetual inventory (Fig. 1) should be kept to record the date, to whom dispensed, the amount and size of the narcotic and the balance remaining in stock. A separate page for each narcotic would show exactly the amount left in the pharmacy and also the usage over any period.

A second record called the floor record (Fig. 2) is needed to list every dose administered and to account for each narcotic requisition used. The receipt is signed when the narcotics are delivered to the nursing unit. One sheet is used for each narcotic, eliminating possible errors and covering the quantity dispensed. A standard unit is from 15 to 25 or 50 tablets, or the quantity which would be used within 48 hours. When completed, this form, accompanied by the empty vial, is a request for a new supply from the pharmacy. A new floor record is used and after the nurse in charge has signed the new receipt, it replaces the old one in the file.

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Fig. 2. Narcotic—Floor Record Form

Fig. 3. Nursing Service—Eight-Hour Narcotic Count Form

Fig. 4. Purchase Record Form

Such a report with accurate data



Now **ACTH** AT SUBSTANTIALLY LOWER COST  
A STABLE SOLUTION OF

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All claims made for CORTICOTROPIN SOLUTION Wilson in this advertisement have been approved by the Council on Pharmacy and Chemistry of the American Medical Association.

The Wilson Laboratories, a division of Wilson & Co. Inc., a leader in the meat processing industry—have pioneered the development of fine pharmaceuticals for more than 33 years.

The Wilson Laboratories announce new major advancements in ACTH therapy.

Now, for the first time CORTICOTROPIN . . . the generic name for ACTH adopted by the American Medical Association . . . is available:

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covering the complete costs and income of the pharmacy can be submitted to show the economic value of efficient pharmaceutical service to the hospital.

**Drug policy.** Development of a sound pharmacy program requires close cooperation between the pharmacist and the other professional groups concerned. Necessary control of pharmaceutical usages in the hospital is best handled by a group upon which the administrator can depend for recommendations concerning types and amounts of drugs to be available

in the pharmacy and concerning therapeutic practices in general.

**Therapeutics and pharmacy committee.** Physicians, representing the medical staff, in collaboration with the pharmacist should comprise the therapeutics and pharmacy committee. This committee establishes and maintains the drug policy for the hospital, and determines what drugs are most useful and economical to carry in stock. The committee should decide the preparations to be stocked where articles are known to have similar compositions and action but differ in brand

name or manufacture. This is advisable because of the expense involved in carrying a large stock of infrequently used items and because of the economies that are involved when standard pharmaceuticals are purchased in quantities.

**Hospital formulary.** The therapeutics and pharmacy committee should develop or adopt a suitable formulary of selected medications. This should be revised from time to time. The use of a formulary should not be so inflexible as to restrict the physician, but an active committee can overcome this obstacle. The use of a formulary curtails expensive inventories, cuts costs in the manufacturing program to reduce the cost of medications, and has many other advantages. The "Formulary, University Hospital, Ann Arbor, Mich.," is an example of the many excellent hospital formularies. In addition, there are several sources for obtaining a listing of drugs to use as a basis for the hospital formulary. "Remington's Practice of Pharmacy" and the "Hospital Pharmacy—Equipment and Supply List," prepared by the Division of Hospital Facilities, Public Health Service, may be adapted for this purpose. The drugs which are to be kept in the nursing units and elsewhere should be enumerated by the committee as should the "ordinary drugs" to be dispensed without charge to patients.

#### SERVICE FOR SMALL HOSPITALS

Many hospitals too small to be able to afford a full-time pharmacist have adopted one of several solutions to this problem in order to provide competent pharmaceutical service.

1. The employment of a full-time pharmacist as chief of the pharmaceutical service, which may require 25 to 50 per cent of his time, who also is utilized in one or more of the following activities: (a) *Purchase and supply*—The pharmacist with knowledge of hospital material, source of supply and buying, could well handle the purchase and control of all supplies, besides the usual pharmaceuticals. (b) *Laboratory or x-ray*—With some special training he could serve part time in the clinical laboratory, x-ray department or in some other professional capacity.

2. The employment of a qualified pharmacist on a part-time schedule. (a) Two or more small hospitals sharing the services of one pharmacist, if the traveling time between the hos-

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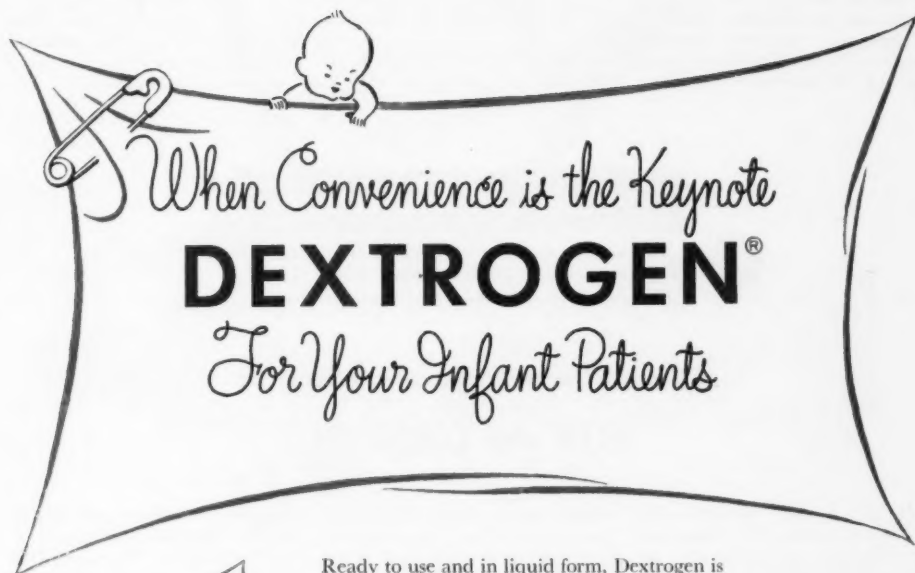


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Ready to use and in liquid form, Dextrogen is a concentrated infant formula, made from whole milk modified with dextrans, maltose, and dextrose. In addition, it is fortified with iron to compensate for the deficiency of this mineral in milk. Diluted with 1½ parts of boiled water,\* it yields a mixture contain-

ing proteins, fats and carbohydrates in proportions eminently suited to infant feeding. In this dilution it supplies 20 calories per ounce.



The higher protein content of normally diluted Dextrogen—2.2% instead of 1.5% as found in mother's milk—satisfies every known protein need of the rapidly growing infant. Its lower fat content makes for better tolerability and improved digestibility.

Dextrogen serves well whenever artificial feeding is indicated, and is particularly valuable when convenience in formula preparation is desirable.

\*Applicable third week and thereafter; 1:3 for first week, 1:2 for second week.



#### NOTE HOW SIMPLE TO PREPARE

All the mother need do is pour the contents of the Dextrogen can into a properly cleaned quart milk bottle, and fill with previously boiled water. Makes 32 oz. of formula, ready to feed.\*

**THE NESTLÉ COMPANY, INC.**  
COLORADO SPRINGS, COLORADO

pitals is not too great. This is part of the philosophy of the coordination of hospital services. (b) Obtaining the services of a registered pharmacist employed in a local retail pharmacy. He could be at the hospital every other morning, two mornings a week, or on

a schedule that is mutually agreeable.

3. Contracting with the proprietor of a well established local retail pharmacy for the hospital pharmaceutical service.

A well trained, competent hospital pharmacist can provide an efficient,

professional pharmaceutical service in place of the mechanical issuance of drugs. He renders many services in addition to those which have been mentioned. He contributes, with other professional personnel of the hospital, to the better care of patients.

## Notes and Abstracts

Prepared by the Committee on Pharmacy and Therapeutics  
University of Illinois College of Medicine, Chicago 12

### *Biological and therapeutic effects of*

## **ACTH and CORTISONE**

IN 1949 Kendall and Hench and their co-workers and Thorn and his colleagues introduced into the therapeutic armamentarium the steroid hormone Compound E (cortisone) and the adrenocorticotrophic hormone of the anterior pituitary gland (ACTH). These agents have proved to be remarkably efficacious in the treatment of numerous diseases which formerly were treated without great success by ordinary technics. The hormones, furthermore, have already been valuable tools for the study of the fundamental mechanisms of disease processes and the reactions of the organism to pathogenic agents. Finally, whatever their ultimate place in therapeutics may be, ACTH and cortisone have perhaps presaged a new concept of therapy, *i.e.* that the deliberate induction of hormonal imbalance in a patient without obvious endocrine deficiencies may result in remission of a disease, if not in its actual cure.

Previous articles in this series have discussed useful tests of adrenal cortical function and the physiology of the pituitary-adrenal relationship. This paper will attempt to summarize the uses of cortisone and ACTH in therapy and the physiological bases for these uses insofar as they might be known.

### **Nature of ACTH**

The adrenocorticotrophic hormone can be isolated as a protein from the

anterior pituitary glands of numerous species. Irrespective of the source or of the species to which the hormone may be administered the effects of adrenal cortical stimulation are qualitatively the same. Differences in the end results of ACTH administration are a result of the varying capacities of the adrenal cortices of individuals or of different species to secrete cortical hormones.

Although ACTH is isolated as a heat stable protein of relatively high molecular weight, experiments have indicated that the effect of the hormone resides in low molecular weight, seven amino acid peptide chains. After hydrolysis and dialyzation of ACTH, the resulting dialysate may be shown to be a more potent stimulant of the adrenal cortex than was the parent hormone. Such findings make real the possibility of synthesis of ACTH-like substances or the synthesis of "hormonal fragments" having some or all of the biological properties of their naturally occurring models.

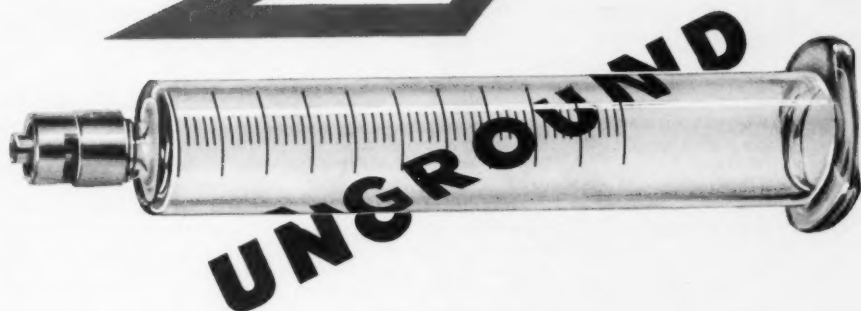
Response to the therapeutic administration of ACTH depends on the presence of functional adrenal cortical tissue; preliminary tests must always be performed to determine the secretory ability of the patient's adrenal cortex before therapy with ACTH is begun. The response of the adrenal gland to stimulation with ACTH is one of hypertrophy and increased secretion; these secretions in turn in-

hibit the endogenous secretion of ACTH. Consequently, withdrawal of ACTH therapy may be succeeded by a brief period of relative adrenal insufficiency. Since the physiological effects of ACTH are the effects of the hormones of the adrenal cortex and remarkably similar to those of cortisone, no special discussion is needed of the biological effects of ACTH.

### **Chemical Nature of Adrenal Steroids**

In spite of the number of studies which have been made of the adrenal steroid hormones, it is unknown which of the compounds whose effects are summarized in the figure occur naturally in the adrenal cortex of man. The effects of the hormones of the adrenal cortex can be correlated with their chemical structures. In order for the compounds to have any effect, it is necessary that there be a double bond between the 4 and 5 positions, a ketone group in the 3 position, and a ketol group attached to the 17 carbon atom of the molecule. With additional ketone or hydroxyl groups in the 11 and 17 positions, the effects of the hormones on carbohydrate and protein metabolism are progressively increased while effects on electrolyte balance are diminished. In the cases of compounds F and E, introduction of an hydroxyl group in the 17 position confers on the molecules their therapeutic properties utilized in the treatment of such diseases as rheumatoid arthritis.

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Differing from the ordinary ground-glass hypodermic syringe, the barrel of the new B-D DYNAFIT® SYRINGE is molded to fit its plunger, *not ground*. This means:

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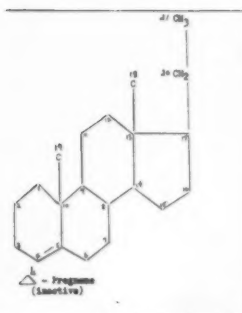
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	Name	Code Name	Number of Oxygen Atoms	Glucogenic Effect	Lymphopenic Effect	Sodium Retention	Anti-Inflammatory Effect
	11-Desoxycortisone	DOC	3	0	0	+++	0
	11-Dehydrocortisone	A	4	+	+	++	0
	Cortisone	B	4	+	+	++	0
	17- $\alpha$ -Estradiol-11-Dehydrocortisone	E	5	++	++	0 = +	++
	17-Hydroxycortisone	F	5	+++	+++	0 = +	++

### Biological Effects

The biological effects of Compound E (cortisone) in man may be divided into two groups: the physiological and the pharmacological. In low doses (25 mgm. per day or less) cortisone in combination with desoxycorticosterone can effectively maintain life in a patient with Addison's disease, and eliminate most of the signs and symptoms of the disease; such doses must indicate the quantity of cortisone essential for normal physiological function. In somewhat higher doses (50 to 100 mgm. per day), cortisone may produce intensified physiological effects, causing decreased carbohydrate utilization, slight salt retention, increased urinary nonprotein nitrogen, and minimal hematological changes (lymphopenia and eosinopenia).

Finally, in doses of 100 mgm. per day or more, the physiological effects of cortisone are increased still more and the anti-inflammatory (pharmacological) properties of the drug are manifested. Whether this anti-inflammatory effect is the result of an intensification of the physiological effect as a phenomenon of "overdosage" or is independent of the physiological effect has yet to be learned. Certainly, under the conditions of ordinary use, the physiological effects of cortisone are side effects to the desired anti-inflammatory effects.

The effects of cortisone in diminishing carbohydrate metabolism is accomplished by an increased deposition of glycogen in the liver as well as by a probable decrease in peripheral glucose utilization, as evidenced by a decrease in the respiratory quotient. As a consequence of decreased carbohydrate utilization, cortisone induces gluconeogenesis, with resulting hyperglycemia and occasional glycosuria. Increased

utilization of protein as an energy source results in a negative nitrogen balance which may be alleviated by increasing the patient's protein intake. Evidence of increased protein catabolism is manifested early in the course of therapy with cortisone by uricosuria and an increase of the urinary uric acid/creatinine ratio, although this effect may be intensified by a lowering of the renal threshold for uric acid.

Fat metabolism is increased by cortisone for the same reason as is protein metabolism but can be demonstrated ordinarily only by a decrease in the respiratory quotient, although occasionally hyperlipemia may be produced. In general, the condition of the patient treated with cortisone (or ACTH) would seem to be similar to that seen in diabetes mellitus and, in fact, a typical "diabetic" glucose tolerance curve is produced by the administration of cortisone. However, the state is not one of true diabetes since ketotic acidosis seldom, if ever, occurs and the state is more resistant to insulin than is true diabetes mellitus.

Although cortisone is known to induce salt excretion in some species, clinically it is observed that the administration of cortisone or ACTH results in a period of sodium retention, occasionally followed by a period of diuresis and sodium and chloride excretion. During the period of sodium retention pitting edema, hypertension, and even cardiac failure as a result of hypervolemia may be observed. Accompanying sodium retention is the loss of potassium and chloride ions in the urine. Failure to compensate for these electrolyte changes may lead to signs of hypokalemia and alkalosis in the patient.

The intimate relationship of the adrenal glands to the other glandular

systems can be observed during the course of therapy with cortisone and ACTH. Decreases in protein-bound iodine in the blood and diminished radio-active iodine uptake by the thyroid gland indicate a diminished activity of that gland which may be masked (insofar as thyroid activity is measured by the basal metabolic rate) by the calorogenic effects of cortisone itself. Cortisone and ACTH also produce effects typical of hyperandrogenism, such as acne, and hirsutism and amenorrhea in women. In contrast to ACTH, cortisone induces a relative atrophy of the adrenal glands, presumably as a result of inhibition of the secretion of the adrenocorticotrophic hormone by the anterior pituitary. Withdrawal of cortisone therapy is followed by a brief period of adrenal insufficiency which may be so severe as to require resumption of therapy.

Two other effects of cortisone and ACTH merit mention because they may be contraindications to the use of the agents; the mechanisms by which these effects are produced is not known. Both drugs produce a distinct change in effect, generally a euphoria, which may proceed even to frank psychosis, particularly in patients with a history of neurotic or psychotic behavior. Hypertension more severe than can be accounted for simply on the basis of salt retention may occur during therapy with either drug and may necessitate cessation of therapy.

As Addison's disease is the typical picture of adrenal insufficiency, so Cushing's syndrome is the exact clinical counterpart of overdosage with ACTH or cortisone. Fortunately, by careful clinical observation and judicious use of laboratory procedures, the undesirable side effects of ACTH and cortisone therapy can be detected or anticipated

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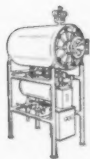
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and corrected or prevented. The side effects of these drugs are, however, potentially dangerous to the life of the patient, and the use of cortisone or ACTH implies that the physician is aware of the importance of the side effects and their physiological significance.

Because ACTH and cortisone have been available for only a few years, any long-term clinical evaluation of their effects is precluded, but their usefulness in certain conditions is now fairly well established. Clinical responses to either of the two drugs are usually similar and the choice of the drug to be used depends on factors which vary with each patient. When a rapid response is essential, ACTH may be the drug of choice inasmuch as it is the more rapid acting of the two agents. When continuous maintenance therapy is required cortisone administered orally is probably the drug of choice; because ACTH is a protein it must always be given intramuscularly or intravenously. Unpredictable variations in clinical response sometimes require the administration of one drug in preference to the other.

Clinical evaluation of the effects of cortisone and ACTH early in treatment includes depression of fever and inhibition of inflammatory reaction and diminution of pain, a feeling of well-being, and increased appetite. Laboratory findings which indicate a systemic response to either of the two agents are a drop in the number of circulating eosinophiles, a gradual decrease in the erythrocyte sedimentation rate, and, in the case of ACTH, an increased urinary excretion of 17-ketosteroids.

Patients for whom prolonged administration of cortisone or ACTH is contemplated should have base-line determinations of fasting blood sugar level, serum sodium and potassium determinations, when practicable, and an electrocardiogram. Frequent weight determinations should be made during therapy, since weight gains are a sensitive indication of beginning edema, and urine samples should be tested for sugar at least once a week during the course of therapy.

Replacement therapy with cortisone and ACTH has proved extremely successful, although the number of patients requiring such therapy is fortunately very small. Addison's disease is now treated with small doses of cortisone and desoxycorticosterone acetate (DOCA) and a diet high in salt.

Panhypopituitarism responds well to ACTH and hypoadrenalism associated with pseudohermaphroditism can be treated effectively with cortisone. Adrenalectomy performed to control hypertension or to slow the growth of prostatic carcinoma leaves the patient with a surgically induced adrenal insufficiency that can be treated post-operatively with cortisone and the adjunctive therapy mentioned.

Both cortisone and ACTH may be used as supplemental therapy in the small number of patients who have adequate "day-to-day" adrenal cortical activity but insufficient adrenal reserve to carry them through such periods of stress as surgical procedures. These patients may go into a state of shock during or after surgery which is resistant to all the usual therapeutic measures. Such patients may develop severe hyperthermias and their serum sodium levels may drop in spite of ordinary sodium replacement therapy. The response to ACTH or cortisone supplemental therapy is often dramatic in such cases. Although an immediate acting adrenal cortical extract is usually administered during the acute phase of the stressful situation, cortisone has proved particularly valuable as prophylactic and maintenance medication until the period of stress has passed.

#### Effect Against Disease Processes

Perhaps the greatest number of diseases which have been found to respond to ACTH and cortisone have no clear causal relation to hypofunction of the endocrine glands. These diseases (hypersensitive states, the so-called "collagen diseases," diseases of the eye, and certain dermatoses) are characterized by an acute inflammatory reaction involving chiefly connective tissue and blood vessel walls and resulting in the deposition of much collagen and intercellular ground substance. Cortisone and ACTH are most effective in combating necrotizing and proliferative inflammatory processes, particularly when they are allergic or anaphylactic in nature. The effectiveness of the agents seems to be equal against sensitivities to bacteria, bacterial products, or allergens such as ragweed pollen or drugs like arsenic or penicillin. It has even been postulated that all of the disease entities amenable to therapy with ACTH and cortisone may be classified as manifestations of hypersensitivity.

The pharmacological effects of ACTH and cortisone in therapy appear

to be unrelated to any metabolic or biochemical effects of adrenal cortical hormones which have been demonstrated thus far. Experimental study of the effects of cortisone and ACTH on various components and concomitants of the inflammatory response has provided precise descriptions of the actions of the drugs without providing too much insight into the mechanisms by which the effects are produced. The administration of either hormone to a patient with an elevated erythrocyte sedimentation rate results in a rather prompt lowering of the rate, and this effect may be related to the action of cortisone on protein metabolism; cortisone is known to decrease the quantities of gamma globulin and fibrinogen formed in the body and the sedimentation rate varies inversely to the concentration of these proteins in the plasma. Hence, the clinical response to cortisone in a case of rheumatic fever may be poor and completely dissociated from the response of the sedimentation rate formerly considered to be an accurate index of the activity of the disease while therapy was being carried out.

Fever is a usual accompaniment of an inflammatory process and both ACTH and cortisone have a marked antipyretic effect which is not only observed clinically, but is exerted even against the pyrogenic effect of dead typhoid bacilli injected intravenously. Since no inflammatory response is involved in the latter case, it would seem that the anti-pyretic effects of the hormones in such a disease as rheumatic fever need not necessarily be related to their anti-inflammatory effects.

Cortisone and ACTH prevent the effects of antigen-antibody union in the organism only under conditions which are as yet incompletely defined. For example, passive transfer of antibodies is possible when the donor has been treated with cortisone, but the Arthus phenomenon in animals can be suppressed by adequate doses of either hormone. Certainly cortisone does not prevent antigen-antibody union, since *in vitro* anaphylaxis is not prevented by the drug. The effects of cortisone and ACTH on antibody formation and release seem to depend on the duration of immunization, the duration of hormone therapy, and the time during immunization when therapy is begun. We can only say that ACTH and cortisone mitigate hypersensitive reactions without specifying how this modification of the response is produced.



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The effects of cortisone on the inflammatory process *per se* are exerted chiefly upon the cellular elements that take part in the early response to tissue injury: the polymorphonuclear leukocytes, fibroblasts, and probably vascular endothelium. The ultimate effects of cortisone is to delay the inflammatory response so that a week-old wound in a cortisone treated patient may have the appearance of a four day-old wound in an untreated subject. In all cases, and irrespective of the cause of the injury, cortisone in larger doses decreases the migration of leukocytes into the traumatized area and diminishes fibroblastic proliferation and the deposition of intercellular material. Since these effects can be produced without affecting the general metabolism of the organism by topical administration of cortisone, it seems justifiable to conclude that certain of the anti-inflammatory properties of cortisone can be exerted independently of systemic effects. The delay in the inflammatory response produced by cortisone is similar to that produced by a protein deficient diet and can be antagonized by the administration of a high protein diet. Since some of the anti-inflammatory effects of cortisone can also be reversed by the administration of sulfhydryl donors, such as glutathione, and the administration of ACTH to man results in a lowering of blood glutathione, it is possible that the mode of action of the hormones may be found to be an interference with the metabolism of the sulfur-containing amino acids, cystine and methionine.

Since the therapeutic effects of cortisone and ACTH have been tested in an overwhelming number of conditions, discussion of the uses of the drugs must be limited to a few selected diseases in which the agents have been shown to be of real value. Dosage with both of the hormones varies with the disease under treatment, the stage of the disease during which therapy is begun, and the individual patient; dosage is varied in any case according to the response of the patient and the incidence and severity of side effects. The clinical literature and clinical experience must be the physician's guide to dosage.

Bronchial asthma, perhaps the commonest of the hypersensitive states, responds well to both ACTH and cortisone during acute episodes and some patients can be maintained symptom free with small doses. It should be emphasized, however, that neither drug

will alter the structural changes produced by long standing diseases, which are pulmonary emphysema and right ventricular hypertrophy. Furthermore, patients who are well controlled with drugs less likely to cause serious side effects, such as epinephrine and aminophylline, should be maintained with these rather than with hormone therapy.

Hay fever, as well as asthma, responds to small doses of both ACTH and cortisone and one or two treatments at the beginning of the season may suffice to keep the sufferer free during the entire period. Again, until further data are obtained, the usual courses open for therapy should be exhausted.

Drug reactions and serum sickness respond quickly and dramatically to ACTH and when the precipitating factor is removed continuation of treatment is rarely needed for more than a week.

The so-called "collagen" diseases, all involving connective tissue, though not specifically collagen, can often be helped remarkably during acute phases by hormonal therapy. These diseases include disseminated lupus erythematosus, periarteritis nodosa, scleroderma, dermatomyositis, rheumatic fever, and rheumatoid arthritis in all forms. ACTH and cortisone are most valuable during the acute exacerbations which characterize all of these diseases, and may be life saving. They alleviate pain, fever and the marked inflammatory reactions which are often seen in these flare-ups, and may reduce deformities when these are of short duration and have not altered bony structures. They do not cure the diseases, however, and although some patients may be maintained on small daily doses, this is frequently impossible and the therapy must be reserved for when it is most needed. Since all of the entities are naturally subject to remissions and exacerbations, frequently treatment may be continued until a normally occurring period of quiescence sets in. It is sometimes seen that following the withdrawal of ACTH or cortisone the process which was being treated suddenly becomes much worse, occasionally worse than before treatment was started, a phenomenon probably explained by the physiological depression of the adrenal cortex during and after the administration of either drug. In such cases the medication may have to be restarted or, if the process is not overwhelmingly acute, the period of several days before the patient's own gland

takes over may be weathered with symptomatic therapy alone.

The acute inflammatory diseases of the eyes respond in general very well to both ACTH and cortisone. Cortisone can be applied topically or subconjunctivally, as well as given systemically, and all three routes have been highly successful in treating lesions which previously were almost untreatable. Iritis, conjunctivitis, superficial keratitis, sympathetic ophthalmia, and acute secondary glaucoma are only a few of the processes which have been successfully ameliorated.

Acute inflammatory skin diseases such as pemphigus, acute psoriasis, and exfoliative dermatitis may be helped by ACTH and cortisone, and if, as in the case of exfoliative dermatitis, the offending agent can be found and removed, a cure can be effected. The other two diseases frequently require maintenance dosage, and in chronic cases already existent skin changes cannot be altered.

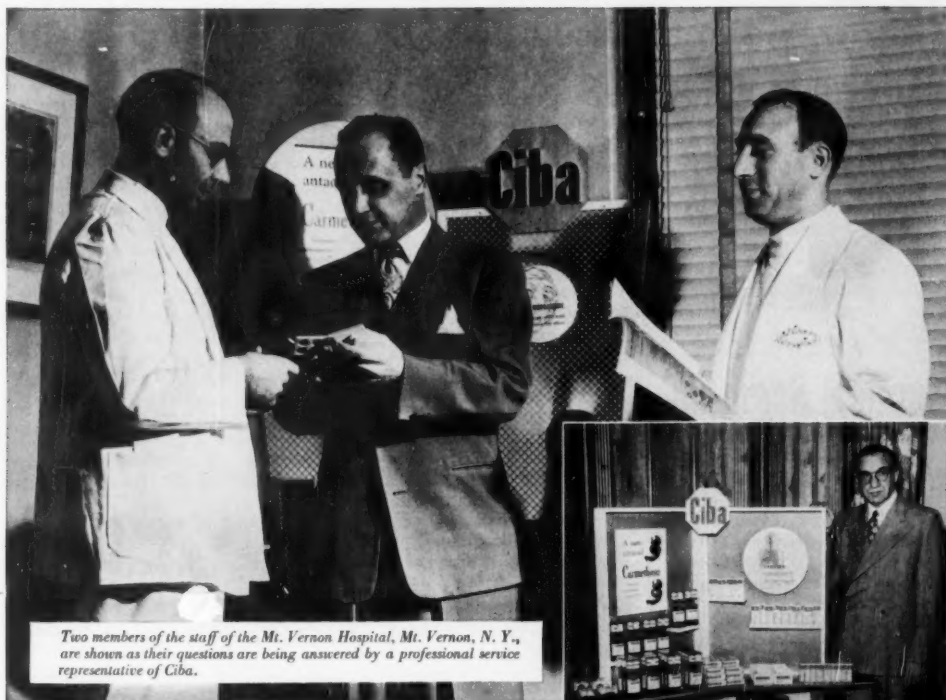
Miscellaneous uses of the two drugs include the treatment of severe burns, in which ACTH especially shortens the period of shock, decreases serous oozing, helps to keep temperature down, and increases the feeling of well-being of the patient both nonspecifically and through the alleviation of pain. Use of the drugs during the nephrotic syndrome is made not for the direct effect on the entity but because a diuresis usually follows abrupt cessation of short periods of therapy. Acute episodes of ulcerative colitis also respond to ACTH and chronic cases may sometimes be helped by daily maintenance doses.

Both cortisone and ACTH have nonspecific effects of considerable value in the treatment of many diseases. Weakness, fatigue, anorexia, and pain are not infrequently ameliorated by these hormones even when no objective improvement in the patient's condition has occurred. While this sort of response may be of value in therapy, it is no warrant for indiscriminate use of the agents.

### Relative Contraindications

The toxic effects of both ACTH and cortisone have already been discussed and it should again be emphasized that these are primarily exaggerated physiological phenomena. They must be kept in mind at all times by the physicians using the drugs, and some of them may be prevented or at least counteracted by simple precautions. Patients who are





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to be treated for any prolonged period should be placed on a low salt diet to minimize the effects of salt retention. Supplementary potassium should be given by mouth or intravenously if necessary. Serum potassium levels should be determined periodically or electrocardiograms should be taken inasmuch as potassium deficit usually produces characteristic changes in the tracings. If hyperglycemia is produced to the extent that the patient is losing a large number of calories resulting from glucosuria, insulin should be started or the hormones should be discontinued.

Mood effects are perhaps most difficult to treat. If the patient becomes severely agitated the drugs should be stopped, but less severe manifestations may be lessened with any of the ordinary sedatives. The development of hypertension severe enough to require discontinuation of treatment is a rare relative contraindication to the use of ACTH or cortisone, but a patient with previously existing hypertension should be given the drugs only after careful thought and planning as to the limitations of treatment. Low salt intake must be rigorously followed, and both the physician and the patient's family should be aware of the risk involved. A second relative contraindication to treatment is an already existent diabetes, but with careful following of diet and judicious increase in insulin, if necessary, the diabetic may be safely treated.

The existence of congestive heart failure is a third relative contraindication, unless this happens to be due to serous pericarditis which might be cleared with hormonal therapy. In general, however, the increase in salt and water retention produced by the ACTH or cortisone is detrimental to the clearing of the congestion.

### Absolute Contraindications

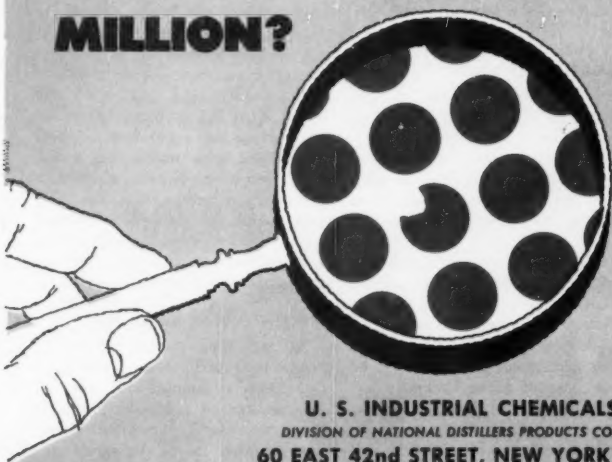
In addition to the relative contraindications to the use of ACTH or cortisone, several absolute contraindications also exist. Both active and chronic tuberculosis may increase in severity during cortisone or ACTH therapy; in this instance fibrosis and walling off of the area of infection is essential to the survival of the patient, but is inhibited by cortisone. Chronic glomerulonephritis, too, is increased in severity by both of the hormones. Cortisone increases the acid and peptic secretions of the stomach, and peptic

ulcers may perforate owing to lysis of fibrous tissue during the course of treatment of an associated disease with either cortisone or ACTH. Although these effects of the hormones may be inimical to therapy with the hormones in patients with peptic ulcer, the phenomenon may be of value in the study of the etiology and pathogenesis of the disease. Finally, psychotic or pre-psychotic states absolutely contraindicate ACTH or cortisone therapy, since full-blown psychoses may be precipitated in the latter case and existing psychotic states may be made worse.

Certain general principles of therapy apply to the use of both ACTH and cortisone which condition the therapeutic response that can be expected after the administration of the agents. Greatest success in treatment occurs in cases which are treated soon after the onset; severe cases of any disease in which considerable amounts of degenerative change have occurred are thereby less amenable to therapy. Best results from therapy are obtained in treatment of disease in which there is a large component of an acute inflammatory response involving limited tissue systems, such as occur in the eye. Finally, diseases which are normally self-limited respond better to therapy with ACTH and cortisone than do diseases which are more chronic. In any case, neither ACTH nor cortisone is able by itself to effect cures; only remissions, reversals and inhibition of pathological processes are possible with these agents. Neither ACTH nor cortisone is an adequate substitute for more specific therapies when they are available. In chronic diseases not amenable to specific therapy, continuous maintenance therapy with one of the hormones may be required for the patient's well-being and comfort, but even such prolonged therapy is no guarantee against exacerbations of the original condition or against the onset of dangerous complications to it.

As we might expect of substances which occur naturally in the organism and seem to have a regulatory function, the therapeutic effects of both ACTH and cortisone are limited. Their net effects seem only to be an intensification and reinforcement of the defense mechanisms which ordinarily obtain in the animal body. The side effects incident to this reinforcement are simply the result of hormonal and metabolic imbalance.—EDWARD PELIKAN, M.S., M.D., and JANET WOLTER, M.D.

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## Food and Food Service

Conducted by Mary P. Huddleson

### 3000 Dietitians Throng Cleveland for American Dietetic Association Meeting

THE 1951 meeting of the American Dietetic Association was a session of dramatic contrasts, in the light of the first national conference of dietitians which convened in Cleveland 34 years ago. Then, in October 1917, there were 38 members; in October 1951 there are more than 9000, distributed over 46 affiliated state associations, the District of Columbia and Hawaii. The yearly operating budget, once at a low of \$200, now approaches \$260,000. The topics presented for discussion, 10 in 1917, now reached a total nearly 10 times that. And the facilities housing these annual conferences, once adequately ensconced in a limited area of the basement of the Lakeside Hospital in Cleveland, now taxed the facilities of the city's vast auditorium and its major hotels as well. The grand ballroom of the Hotel Statler fairly burst with the throng attending the annual dinner when the exhibitors are entertained as guests of the association, for the original four had now grown to well over 100.

#### SERVICE MOTIF PREDOMINANT

In one respect, at least, change was not so evident. The major interest still is in the hospital field (more than half the membership) with service to the community and the nation predominant. As in 1917, the 1951 sessions opened on the note of the dietitian's rôle in national and civil defense. In the words of Dr. Margaret A. Ohlson, incoming president, "The dietitian has long been a member of the medical team. She is accustomed to team play. As a member of a team, she has served through two world wars. I believe I can pledge to you that she is ready to serve again in this emergency."

By MARY P. HUDDLESON

Plunging into a lively week, busy groups were soon engrossed in conferences on food cost control, floor planning and placing of equipment, food purchasing specifications, nonprofessional supervisors in the dietary department, dietary consultation to small hospitals, technics of interviewing patients, work simplification, sanitation, job descriptions, quality food production and its close relative, public relations.

#### ESTIMATE SPACE NEEDS

For those who are able to start afresh, Mrs. Vivian Laird, director of dietetics, Miami Valley Hospital, Dayton, Ohio, warned that "When a dietitian is called upon to assist in planning a new dietary department there are certain factors which must be settled and agreed upon by her administrator and the architect before detailed plans can be started: number of beds, type of tray service, location of dietary department and amount of space to be allocated." Space for the dietary department is estimated to be on the basis of 12 to 15 square feet per bed. Mrs. Laird then itemized the eight advantages and six disadvantages of centralized *versus* the six advantages and eight disadvantages of decentralized food service.

Another currently moot question was discussed at a conference in which hospital administrators and their dietitians participated—that of china *versus* plastic ware. A year's preliminary study was made more or less independently by the administrator, J. Milo Anderson, and the dietitian, Mrs. Martha Nelson Lewis, before the new

600 bed hospital at Ohio State University was equipped. While the original cost of the plastic was not significantly different from that of the china, the replacement cost of the former was less than half that of the latter because of greater durability of the plastic, they reported. Although plastic ware is admittedly less scratch-resistant than china, other factors in favor of plastic were reported to be sufficiently conclusive to influence the decision in favor of its purchase. Other factors named were the lightness which made handling less fatiguing to workers, less noise in handling, better retention of temperature, and preference of both employees and patients for the plastic ware. Bacteriological assays did not indicate any superiority of china over plastic as to sanitization, it was stated, despite the fact that plastic does not air-dry as well as china does. The only problem yet to be settled is whether long-continued exposure of the plastic to high temperatures would harm the plastic dishes now in use.

#### SUPERINTENDENT NEEDS HELP

At the same session Stanley A. Ferguson, superintendent, Cleveland City Hospital, pointed out that the "complexities of present-day hospital operation make it impossible for the superintendent to be intimately acquainted with all the hospital activities, hence each department head must assume a larger rôle in the administrative functions of the hospital." His co-superintendent and dietitian, Elizabeth Perry, urged that dietitians employ the work principles used in industry as far as these are applicable, and stressed that good personnel relationships are the first step toward good public relations.



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Methods of better food cost control seemed to weigh heavily on the delegates. Margaret Terrill of the University of Seattle, presiding at one of the conferences, urged control of costs under the firm hand of the dietitian as a prime requisite to a department's success. Persons remote from the department, she stated, are likely to expect fillet of tenderloin on a budget scarcely adequate for well-diluted hamburgers. The dietitian who hides behind the screen of mere menu-making, she said, "can expect to have her tail feathers fanned by the buckshot of criticism."

#### PLANNING IS NOT EASY

Elizabeth Huey, L. S. Ayres and Company, Indianapolis, agreed that planning diets in institutions is not an easy task. Meals must provide the right kinds of food for individuals who may vary greatly in their nutritional needs and food likes. Meals must be of the type that can be prepared with the available staff and equipment, and food costs must be kept within a definite ration allowance. Many institutions do not know whether the food served provides the dietary essentials, Miss Huey asserted, yet this information can easily be obtained by using a procedure commonly called "Nutritional Accounting." In such accounting, she explained, the nutritive value of the quantities of food (grouped according to similarity in nutritive content and use in meals) that are issued per ration per day is computed by using average food values for the respective groups.

A comparison of the quantities of major nutrients obtained in this manner with the quantities recommended by the National Research Council in the daily dietary allowances will provide a basis for appraising the diet. When this is made a part of the regular accounting procedure, descriptive information will be available which if used in conjunction with quantity and cost data will furnish the food manager with basic information that can guide her in planning nutritionally adequate diets.

Another procedure, akin to nutritional accounting, that will provide information on the quality of the diet, Miss Huey continued, is a comparison of quantities of food (by groups) issued per ration, per day or per week, with quantities for similar groups which will provide an adequate diet at a given cost level, such as the

Bureau of Human Nutrition and Home Economics' food plans for institutions. This comparison will indicate the direction that changes in current food usage should take to ensure good diets at a particular cost level.

These two procedures, based on food issues, are rough appraisals of the adequacy of the diet. Although the nutritive values used in the computation allow for normal preparation waste, there is no assurance that the rest of the food issued is consumed. A food manager, however, should have an appreciation of the magnitude of the waste. Knowing this she can estimate the nutritive value of the food consumed. The adequacy of food, of course, can best be judged by periodical determinations of the nutritional health of each resident, but these are time consuming and expensive, Miss Huey pointed out. Nutritional accounting, on the other hand, although not so accurate, is a comparatively easy and inexpensive procedure and information so obtained, when properly evaluated, is sufficiently accurate to point the way to dietary improvement. Nevertheless, as with any other procedure, information gained must be followed by constructive action, the speaker concluded.

A consulting psychologist, Lawrence Lindahl of Rochester, N. Y., said that if the dietitian is to look at her job objectively, she will need to disassociate herself from her job as a dietitian. She must see her total job as an actual object, not merely as an idea.

It has been found that the average person uses only about 30 per cent of his potential abilities on a job, Mr. Lindahl reported. Because they fear loss of security, many persons cast their lot in one job, never knowing that they may have missed opportunities for development of their potential for greater service and personal satisfaction. The greatest contribution to self and society will result from a higher degree of professional competence, whether it is in the least or most influential job hierarchy, he stated.

The dietitian's job is more than preparing food or seeing that it is prepared. It is a controlling of human behavior through the application of knowledge of food and feeding. Dietitians must have a broader concept of their job, avoid getting entangled in details and routine, and be able to put themselves in the other fellow's shoes. Otherwise they cannot utilize their

maximum capabilities, Mr. Lindahl concluded.

Cloyd S. Steinmetz of the Reynolds Metals Company, Louisville, Ky., said that without a sound grounding in the understanding of "what makes people tick" supervision of employees is likely to be the practice of prejudice rather than of principles.

It is regrettable, he contends, that the statement, "the supervisor is an instructor" has almost become a platitude. The responsibility for giving instructions should never become dull and commonplace. The monotony of just "giving" instructions is largely the cause of this attitude. The vital second half of instruction, namely "getting it back" from the learner has been the much neglected factor, Mr. Steinmetz pointed out. Yet this is the half that gives instruction its vitality. Evaluation of work performance and seeing to it that all forms of compensation are applied to the right and wrong discharge of responsibility are frequently overlooked obligations.

A good supervisor, according to Mr. Steinmetz, intentionally and purposefully plans to inspire her workers. Likewise, developing their aspirations is one of the most fruitful ways of making supervision easier.

#### WEIGHT CONTROL PROGRAM

In the field of applied nutrition, a new weight control program, achieving weight losses averaging 1½ to 2 pounds a week with no abnormal "hunger pangs" or disturbances to the dieter's system, was described by Dr. Margaret Ohlson of Michigan State College. This diet contains a high proportion of protein and fat. The food combinations in the diet permit weight loss without the attendant loss of vigor and work capacity, so often associated with reducing diets.

"This diet—like any reducing diet—should be administered under the direction of a physician," Dr. Ohlson said. A typical breakfast is made up of citrus juice, two eggs, toast and butter and milk.

Lunch and dinner include adequate servings of a protein food which may be meat, fish, cheese or poultry or a combination of these. Dairy foods are an essential part of the diet and are included in every meal. A wide choice of vegetables helps to vary the meals. Weight losses under the program have been gradual and regular. A housewife, referred to Dr. Ohlson by her  
(Continued on Page 150)

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# A DIETITIAN REPLIES to the consultant

who "sounded off" on the shortcomings of dietitians

## MARY W. NORTHROP

Chief Dietitian and Housekeeper  
King County Hospital System, Seattle, Wash.

**A**NONYMOUS communications have no validity because the standing of the author, and therefore the worth of his opinions, cannot be judged. Such papers should be ignored. However, lest others may read and give some weight to the article by a hospital consultant in the November issue of *The MODERN HOSPITAL* may a dietitian reply?

1. The consultant says that he believes management of the food service department should be given to someone other than the dietitian. Dietitians took over the management of hospital kitchens from stewards a quarter of a century ago. What he is suggesting is a reversion rather than an advance. Granted that some dietitians try to cover too much territory, might not the answer be to stop refusing to give the dietitian adequate clerical assistance, but to relieve her of detail so that she would be free for supervision?

### WE GET WHAT WE PAY FOR

2. The consultant says he thinks most hospital jobs are underpaid, though not most of the people in them. One gets what one pays for in this world. Professional satisfaction is an incentive, but it is not enough. Dietitians with the quality of leadership and with keen business acumen are doing well in other fields, but hospital salaries are not such as to attract the ablest people or to spur average people to their best efforts. One wonders, however, whether the same salary will be paid to the food manager and, if it is, how good a manager he will be.

3. The consultant says that dietitians are weak on personnel management. Are they? It seems to me that other managers might have difficulty with the type and age of personnel available for hospital kitchens. Again,

there is the hospital salary scale. There is also the hospital tradition of a charitable attitude toward elderly workers. If a hospital is a charity, well and good. Then don't blame the dietitian that it is not a hard-boiled business.

### IT TAKES EXPERIENCE

As a matter of fact, there are many dietitians who are excellent personnel managers, but personnel management takes a little experience in living. The inexperienced food manager would be no better than the inexperienced dietitian. And hospitals have been losing their experienced dietitians at the same time that they have expanded the numbers they require. The membership of the American Dietetic Association has doubled in the last 10 years and cannot nearly keep up with the demand for dietitians. Naturally, these new members are largely the young graduates whom we have been supplying as fast as we can to try to meet the needs of hospitals. They need a little time to gain experience. They have remarkably little personnel trouble compared to other organizations that are under nonprofessional management.

4. The consultant says: "I've heard any number of hospital administrators admit—either outright or by implication—that their weakest point when it came to running their hospitals was their lack of knowledge about kitchen setups and management. I'd say that about 98 per cent of them—and I'm not kidding about that figure—are glad to drop the whole problem in the lap of the dietitian and try to forget about it. Laboratories and surgeries and nursing problems seem to interest them a good deal more than the kitchens do."

Well! That's an indictment of the administrator, not the dietitian. Doesn't that consultant know what the result of the neglect of any department by the administrator is bound to be? The dietitian wants to run her own department, but she also wants, and needs, the same backing by an interested administrator that the consultant says other department heads receive.

4. The consultant says:

"Some day you should see that boiler room they call a kitchen in one of the large hospitals."

### SHE DOESN'T LIKE IT EITHER

I hope you will see it, and take a good look at it, and then ask whether it is that way because of the dietitian's preference. Granted that some dietitians lack imagination and initiative, and are content with physical facilities which any sensible restaurant operator would know must be improved before he could make ends meet, many, many other dietitians request remodeling, reengineering and reequipping, and are refused at every turn. The x-ray machine or something for the operating room or the laboratory has first call on hospital funds, so that even though it might be a real saving to spend money on the kitchen in order to cut operating costs, it is not done. The dietitian knows the need, but since her request for even a 20 dollar item is refused, she grows discouraged. She really believes the administrator the first few times he tells her he cannot afford to meet her needs, but soon she grows skeptical when she sees purchases made for other departments.

"You can get along for the present," she is told.

So she gets along, and grows cynical, and stops asking.



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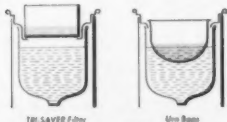
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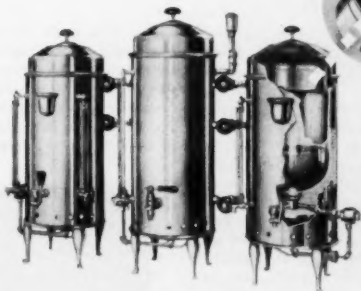
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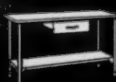
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WORK TABLES

6. The consultant says:

"It was a real pleasure the other day to sit down with an industrial food service designer and watch him rough out a system for a 300 bed hospital. Oh, brother, what a guy like that can do to and for a hospital!"

But the kitchen engineers usually are the people who design hospital kitchens. How many hospital kitchens can you name which were designed by dietitians? Perhaps dietitians would not have done better, but they cannot be held responsible for the present messes. At least, they understand the

problems to be solved. The best arrangement would be for the industrial food service designer and the experienced dietitian to work together as a team when the hospital kitchen is planned. Each has knowledge and skills which the other needs. The food manager would not be an engineer, any more than the dietitian is. State dietetic associations have committees of experienced dietitians available to assist in kitchen planning, but they are not usually consulted early enough in the planning process.

Ah me! It's still a man's world!

## FOOD FOR THOUGHT

### The Ulcer Diet

Except during the acute phases of peptic ulcer when a modified Sippy diet is usually in order, the diet of the ulcer patient need not be monotonous. At such times a mechanically, thermally, and chemically nonirritating diet is in order. This means that all food given must be smooth or finely puréed, neither very hot nor very cold; bland, that is, free of seasonings or flavorings that unduly stimulate the flow of gastric juices or tend to be chemically irritating, such as excessively acid, sweet, salty, or spicy foods, also coffee, tea, carbonated and alcoholic drinks, meat-stock soups, sharp cheeses, and strong flavored vegetables, such as cabbage, onions, radishes and tomatoes.

While every ulcer patient should be considered individually, in most instances these general restrictions which rigidly apply during the acute phases should also be observed in some degree and for varying periods of time following remission of symptoms. But this does not mean that the diet must necessarily be monotonous.

Milk, that highly nourishing food and bulwark of the ulcer diet, whether used fresh, evaporated or dry, offers almost endless possibilities for varied use in the diet. Take the cream soups for instance. As any good cookbook will indicate, the number and kind of cream of vegetable soups need be limited only by one's imagination. Offhand, one thinks of potato, corn, spinach, celery, mushroom, pea, carrot—all of which in turn may be varied by garnishings. Then there are the milk drinks. A well known fruit importing company whose recipe booklets are available to all dietitians, lists seven variations for a delicious banana milk shake ideally suited to the ulcer diet. Again, the number and variety of desserts with milk the chief component seem almost limitless. There are cornstarch, bread, rice and tapioca puddings, custards and junket desserts. "America's Cook Book" lists 12 variations for custards and three for junket. Or if malted milk or an eggnog is your dish, you could have a plain eggnog with a light dash of nutmeg, or a homogenized fruit, a light chocolate or a grape juice eggnog, made with a very little orange and grape juice.

When and if coffee is allowed it is best as café au lait—half hot milk and

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"stock." Every part of the turkey — even the ground-up skin — is usable when cooked this way.

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half coffee. For further ideas on the use of milk in the ulcer diet the dietitian is referred to the National Dairy Council, the Evaporated Milk Association, and the American Dry Milk Institute, all of Chicago. National distributors of milk products also have recipes and other literature available free to dietitians.

In the early stages of treatment meat, if allowed, is usually served ground or minced which somewhat limits variety to lightly broiled patties and creamed dishes. Preferred meats are lean and tender beef or lamb, with

chicken, turkey, sweetbreads, tender liver, whitefish and crisp bacon generally advised. Both meats and eggs offer possibilities for wide variation in preparation. The aforementioned cookbook lists more than 35 recipes for eggs alone. But it should be remembered that certain not always essential ingredients in recipes must be omitted to conform to the basic restrictions which apply in the bland, liberal bland and restricted-residue diets used in gastrointestinal conditions. These restrictions are detailed in the first paragraph of this article.

Cheese is limited to cottage and cream and perhaps later mild American, sliced or in cooking. When we think of fruits our first thought is "no skins, seeds or core." Next, except for ripe bananas and orange juice (which often must be served diluted with water), the fruits must be stewed, canned or puréed, but need not always be served as fruits alone. There is a vast array of gelatin, blanc mange, tapioca, soufflé, escalloped and other types of desserts in which the allowed fruits may be used.

White potatoes, macaroni and its relatives, also rice, lend themselves to great variety in preparation and definitely meet the requirements of the bland diet. Milk and cream, those other bulwarks of the ulcer diet, combine not only esthetically but very nutritiously with the potato and cereal foods. Even though frying is frowned on for potatoes, cookbooks devote pages to ways in which they can be varied while retaining their blandness.

As for vegetables other than potatoes, "tender and soft-fibered" and mild in flavor are the watchwords in your selection, and all must be cooked; unless they are very tender, they should also be puréed. The anti-skin and seeds rule also applies here; hence sieve the tomato and preferably use it in cream soup or a gelatin. Since a fresh, young and tender vegetable needs little glorification except that lent by the addition of good butter or cream and a dash of salt, attention might better be devoted to varying the type of vegetable rather than the preparation. The nutritional well-being of the patient will be furthered by avoiding overcooking and by saving the liquid in which the vegetable is cooked for use in sauces or soups.

As for cereals, any of the many finely milled cereals, cooked and later the ready-to-eat (without bran) are acceptable.

Actually, the convalescent ulcer diet or the bland diet which later should help safeguard the patient from a recurrence of his symptoms need not be monotonous. True, he must avoid all fried foods, all highly spiced and seasoned, all coarse foods, rich gravies, strong coffee and tea and soft and alcoholic beverages. But in so doing he may in time learn to appreciate fully the more delicate, natural flavors of good foods, well cooked and simply served—foods whose original identity is not lost in a mass of sauce and high seasoning.—MARY P. HUDDLESON.

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Synthane Corporation Cafeteria, Oaks, Pa.



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# Menus for January 1952

Vera Keith  
Dietitian  
Battelleboro Memorial Hospital  
Battelleboro, Vt.

<p><b>1</b> Apple Juice Soft Cooked Eggs, Muffins</p> <p>•</p> <p>Cream of Asparagus Soup Roast Beef Mashed Potatoes Pearl Onions Mashed Hubbard Squash Celery, Carrot Grels Frozen Pudding Ice Cream</p> <p>•</p> <p>Cold Smoked Tongue Baked Potatoes Spinach, Hard Cooked Eggs Pears, Oatmeal Cookies</p>	<p><b>2</b> Sliced Bananas Scrambled Eggs</p> <p>•</p> <p>Beef Brisket Broiled Pork Chops Shoe String Potatoes Whole Kernel Corn Perfection Salad Chocolate Marshmallow Ball</p> <p>•</p> <p>Welsh Rabbit Broiled Tomatoes Lettuce Wedge Russian Dressing Fruit Cocktail Ginger Cookies</p>	<p><b>3</b> Orange Juice Bacon, Toast</p> <p>•</p> <p>Cream of Pea Soup Cube Steak Lyonnise Potatoes Brussels Sprouts Asparagus Salad Spice Cake With Lemon Sauce</p> <p>•</p> <p>Chicken Chow Mein on Rice Buttered Beets Celery, Olives Pineapple Chunks Sugar Wafers</p>	<p><b>4</b> Stewed Apricots Soft Cooked Eggs, Buns</p> <p>•</p> <p>Celery Soup Fried Scallops Mashed Potatoes Whole Green Beans Red, Green Cabbage Slaw Apple Betty With Whipped Cream</p> <p>•</p> <p>Escalloped Oysters Chopped Spinach Grapefruit, Orange Salad Iced Cupcakes</p>	<p><b>5</b> Pineapple Juice Poached Eggs</p> <p>•</p> <p>Pepper Pot Soup Veal Frissee With Currant Jelly Parslief Potatoes Sliced Carrots Grapefruit, Stuffed Prune Salad Pumpkin Chiffon Pie</p> <p>•</p> <p>Creamed Salmon Baked Potato Frozen Peas Baked Apple With Ginger Hard Sauce</p>	<p><b>6</b> Sliced Oranges French Toast, Sirup</p> <p>•</p> <p>Vegetable Bouillon Baked Chicken Potatoes au Gratin Buttered Broccoli Pear au Natural Salad Vanilla Ice Cream With Raspberries</p> <p>•</p> <p>Tomato Soup Chopped Beef With Mushrooms Sauté on Toast Julienne Carrots Cherry Lattice Pie</p>
<p><b>7</b> Stewed Prunes Poached Eggs, Coffee Cake</p> <p>•</p> <p>Vegetable Soup Roast Shoulder of Lamb Steamed Rice Green Lima Beans Apricot, Cottage Cheese Salad Orange Chiffon Cake</p> <p>•</p> <p>French Toast Bacon Curls Tomato Salad Caramel Pudding Vanilla Cookies</p>	<p><b>8</b> Pineapple Juice Link Sausage, Muffins</p> <p>•</p> <p>Cream of Pea Soup Broiled Ham Slices With Raisin Sauce Mashed Potatoes Baked Acorn Squash Celery, Olives Peach Upside Down Cake</p> <p>•</p> <p>Creamed Chicken on Toast Mexican Corn Vegetable Salad Fruit Cup Sugar Cookies</p>	<p><b>9</b> Apricot Nectar Bacon Curls</p> <p>•</p> <p>Onion Soup Stuffed Veal Birds Mashed Potatoes Stewed Tomatoes Red Apple and Grapefruit Salad Cream Puff</p> <p>•</p> <p>Curried Lamb With Boiled Rice Buttered Lima Beans Orange Salad Baked Custard Chocolate Chip Cookies</p>	<p><b>10</b> Grapes Omelet, Toast</p> <p>•</p> <p>Chicken Noodle Soup Roast Pork, Dressing Creamed Potatoes Parslief Turnips Cranberry Salad Lemon Sherbet Vanilla Cookies</p> <p>•</p> <p>Hot Turkey Sandwich Escalloped Tomatoes Gingerale Fruit Salad Chocolate Cake</p>	<p><b>11</b> Sliced Oranges Poached Eggs</p> <p>•</p> <p>Tomato Rice Soup Broiled Halibut, Lemon Baked Stuffed Potatoes Wax Beans With Pimiento Lettuce Salad Cherry Cobbler</p> <p>•</p> <p>Codfish Cakes With Pea Sauce Spinach Minted Stuffed Pear Salad Graham Cracker Pudding</p>	<p><b>12</b> Prune Juice Scrambled Eggs</p> <p>•</p> <p>Fruit Cup Corned Beef Parslief Potatoes Cabbage Wedges Glazed Carrots Beet Pickles Apple Pie With Cheese</p> <p>•</p> <p>Spaghetti With Mushrooms au Gratin Grapefruit, Pimiento Salad Floating Island Pudding</p>
<p><b>13</b> Orange Juice Canadian Bacon</p> <p>•</p> <p>Tomato Bouillon Broiled Steak French Fried Potatoes Buttered Cauliflower Stuffed Celery, Olives Butter Pecan Ice Cream Cookies</p> <p>•</p> <p>Fruit Plate Open Grilled Cheese Sandwiches Shadow Layer Cake</p>	<p><b>14</b> Baked Apples Poached Eggs</p> <p>•</p> <p>Consommé Meat Loaf With Mushroom Sauce Sweet Potatoes With Mashed Potatoes Buttered Broccoli Molded Pineapple Salad Sponge Cake</p> <p>•</p> <p>Tuna Fish Salad Baked Potato Asparagus Tip Salad Chocolate Meringue Pudding</p>	<p><b>15</b> Sliced Oranges Poached Eggs</p> <p>•</p> <p>Split Pea Soup Broiled Beef Patty Potatoes au Gratin Buttered Beets Cranberry Salad Peach Cobbler</p> <p>•</p> <p>Salmon Loaf With Eggs, Parslief Sauce Chef's Salad Peppermint Ice Cream</p>	<p><b>16</b> Grapes Bacon Curls, Toast</p> <p>•</p> <p>Corn Soup Roast Leg of Lamb With Mint Jelly Candied Sweet Potatoes Buttered Green Beans Lettuce Wedge, French Dressing Strawberry Tapioca</p> <p>•</p> <p>Beef Stew With Vegetables Pear Half in Lime Gelatin Date Torte With Whipped Cream</p>	<p><b>17</b> Tomato Juice Corn Muffins, Jelly</p> <p>•</p> <p>Cream of Celery Soup Veal Steaks Baked Potato Broiled Tomatoes Avocado, Orange Salad Apple Turnover</p> <p>•</p> <p>Scrambled Eggs With Chicken Livers Waldorf Salad Cherry Gelatin Cubes Vanilla Wafers</p>	<p><b>18</b> Baked Apple Soft Cooked Eggs, Toast</p> <p>•</p> <p>Mushroom Soup Salmon Steak With Lemon Butter Sauce Parslief Potatoes Lima Beans Tossed Green Salad Angel Food Cake</p> <p>•</p> <p>Baked Macaroni, Cheese Lettuce, Tomato Salad Prune, Nut Pudding With Custard Sauce</p>
<p><b>19</b> Apple Juice Bacon, Toast</p> <p>•</p> <p>Noodle Soup Stuffed Pork Chops Mashed Potatoes Creamed Peas Lettuce, Endive Salad Lemon Meringue Pie</p> <p>•</p> <p>Swedish Meat Balls With Tomato Sauce Buttered Spinach Pineapple, Cheese Salad White Cake With Caramel Icing</p>	<p><b>20</b> Grapefruit Half Scrambled Eggs, Buns</p> <p>•</p> <p>Tomato Juice Roast Chicken, Dressing Broiled Potatoes Brussels Sprouts Jellied Apple and Cranberry Salad Orange Sherbet</p> <p>•</p> <p>Canadian Bacon Tomato Sandwich With Rabbit Sauce Asparagus Tips Home-Style Peaches Cookies</p>	<p><b>21</b> Stewed Prunes Soft Cooked Eggs</p> <p>•</p> <p>Vegetable Soup Broiled Lamb Chops Baked Potato Celery, Stuffed Olives Julienne Carrots Coconut Layer Cake</p> <p>•</p> <p>Corned Beef Hash Patty With Poached Egg Cabbage, Green Pepper Slaw Royal Anne Cherries Chocolate Cookies</p>	<p><b>22</b> Grapefruit Half Scrambled Eggs, Bacon</p> <p>•</p> <p>Roast Turkey With Dressing, Giblet Gravy Whipped Potatoes Frozen Peas Creamed Pearl Onions Cranberry Relish Vanilla Ice Cream With Chocolate Sauce</p> <p>•</p> <p>Oyster Stew Assorted Sandwiches Potato Chips Green Gage Plums Fruit Cake</p>	<p><b>23</b> Sliced Bananas Poached Eggs</p> <p>•</p> <p>Turkey Soup Baked Ham With Pineapple Rings Escalloped Potatoes French Cut Green Beans Lettuce Hearts, French Dressing Devil's Food Cake</p> <p>•</p> <p>Italian Spaghetti With Meat Balls Bread Sticks Green Gage Plums Apricots</p>	<p><b>24</b> Orange Juice Bran Muffins, Jam</p> <p>•</p> <p>Celery Soup Roast Pork, Gravy Boiled Rice Mashed Squash Chef's Salad Whipped Raspberry Gelatin</p> <p>•</p> <p>Turkey à la King on Biscuits Asparagus Tips Peach, Cottage Cheese Salad Brownies</p>
<p><b>25</b> Prune Juice Soft Cooked Eggs</p> <p>•</p> <p>Split Pea Soup Broiled Fillet of Sole With Tartare Sauce Mashed Potatoes Harvard Beets Pineapple Salad Baked Custard</p> <p>•</p> <p>Escalloped Tuna Fish With Noodles Grapefruit, Orange Salad Iced Cup Cakes</p>	<p><b>26</b> Blended Juices Link Sausage, Buns</p> <p>•</p> <p>Cream of Corn Soup Swiss Steak Mashed Potatoes Buttered Broccoli Tomato Wedges Orange Chiffon Cake</p> <p>•</p> <p>Stuffed Peppers With Brown Mushroom Sauce Cabbage, Carrot and Raisin Salad Red Pitted Cherries Vanilla Wafers</p>	<p><b>27</b> Tangerines Bacon Curls, Toast</p> <p>•</p> <p>Consommé Prime Rib Roast Baked Stuffed Potato Glazed Carrots Tomato Aspic Lime Sherbet Sugar Cookies</p> <p>•</p> <p>Pepper Pot Soup Cold Sliced Ham Potato Salad Celery Hearts, Olives Cake With Frozen Strawberry Sauce</p>	<p><b>28</b> Pineapple Juice Soft Cooked Eggs</p> <p>•</p> <p>Fruit Cup Broiled Liver, Bacon Escalloped Potatoes Onion Rings Tossed Salad Sponge Jelly Roll</p> <p>•</p> <p>Creamed Chipped Beef Baked Potatoes Pickled Beet Salad Fresh Fruit Cup Date Nut Bars</p>	<p><b>29</b> Grapefruit Juice Omelet, Jelly</p> <p>•</p> <p>Tomato Soup Breaded Veal Chop Whipped Potatoes Buttered Corn Lettuce Wedges, 1000 Island Dressing Gingerbread, Hard Sauce</p> <p>•</p> <p>Corn Chowder Cottage Cheese With Chives, Tomato Sections on Lettuce Whole Wheat Rolls Canned Peeled Apricots Fig Bars</p>	<p><b>30</b> Stewed Prunes Bacon Curls, Toast</p> <p>•</p> <p>Cream of Celery Soup Pot Roast With Pan Browned Potatoes Peas Apple, Celery Salad Lemon Snow With Custard Sauce</p> <p>•</p> <p>Hamburger in Rolls French Fried Potatoes Vegetable Salad Banana Cream Pudding</p>
<p><b>31</b> Sliced Oranges, French Toast, Sirup • Onion Soup, Roast Duckling, Candied Sweet Potatoes, Molded Cranberry Salad, Buttered Broccoli, Rasp- berry Sherbet • Ham Loaf With Mushroom Sauce, Baked Noodles, Lettuce and Tomato Wedges, Royal Anne Cherries, Chocolate Chip Cookies.</p> <p>Ready-to-eat or cooked cereals are offered on all breakfast menus.</p>					



# Hotpoint griddles automatically better!

Shown above is Hotpoint's superb new Griddle model HGG47, now available with twin fully-automatic temperature controls—preheats to 400° in only 15 minutes.

*Every food* has an exact temperature at which it griddles best. Now Hotpoint lets you dial-in that exact temperature and hold it—automatically—for automatically better food results!

Two "HOTPOINT FIRST" features are the big reasons for griddling results finer than you have ever seen before. Exclusive Calrod® Heating Units pour *more* heat into Hotpoint Griddles *faster*! And Hotpoint's exclusive Compensated Hydraulic Thermostat controls the heat *better*!

These two developments automatically combine with other Hotpoint Griddle features to give you...

... **AUTOMATICALLY FASTER COOKING!** For example, the HG2 Griddle is the world's fastest... preheats to 400° in 8 short minutes! The HG3 Griddle-Grill, with top and bottom heat, cooks twice as fast! And all Hotpoint Griddles idle automatically at ready-to-cook temperatures.

... **AUTOMATICALLY LONGER LIFE!** Rugged construction plus clean all-electric operation helps Hotpoint Griddles last up to twice as long as ordinary equipment... so that in the long run they usually cost less to own than even the least expensive griddles.

... **AUTOMATICALLY BETTER QUALITY CONTROL!** With uniform electric heat distribution, products started together finish together to the same perfect degree of "doneness."

So make an automatic choice for your next griddle now—one of the Hotpoint Automatic Griddles shown below. Count on them to give you better food in greater volume at lower cost... automatically!

AND IT'S ALL BECAUSE...

**Hotpoint** *invented cooking*  
the modern way!

Check Boxes Below and Mail Coupon for Free Information



Model HG2

Unit of the Custom-Matched Counter Kitchen, 212 sq. in. usable fry area.



Model G28

For extra counter capacity, 389 sq. in. fry area. Finished in chrome.



Model HG3

Griddle Grill—Top and bottom heat cuts cooking time in half.



Model HGG47

For big kitchen operation, 615 sq. in. usable fry area.



Model HGG47 with HXG8 Stand

Mounts on counter or stand.



**HOTPOINT INC.**  
Commercial Equipment Department  
229 South Seeley Ave., Chicago 12, Illinois

We are interested in the Hotpoint Griddle(s) checked. Please send us additional free information and descriptive literature.

Name

Title  Firm

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FOOD SERVICE EXPERTS  
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## HOTPOINT FIRST

with most important cooking improvements today!



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Food Service,  
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The jury of food-service authorities shown above voted Hotpoint First in Commercial Cooking for such major exclusive developments as:

Calrod Heating Units • Hotpoint SUPERange (with Recipe Robotrol) • Complete Custom Matched Counter Line • First Commercial Roaster (Dutch Oven-ROASTER) • The Magnificent Glamour Line







**Patient CLARK** De-licious! My favorite breakfast to make me feel right at home! (Right! Kellogg's cereals are a tasty treat. Kellogg's cereals are favorites with kids and grown-ups the country over.)



**Nurse DOUGHERTY** I don't know what I'd do without Kellogg's Individuals. They save me time—there's a choice for everyone—and what a cinch to serve!



**Dietitian BROWN** Breakfast planning is so much easier with Kellogg's big assortment of flakes, shredded and popped cereals. And they're healthful too—all either are made from the whole grain or are restored to whole grain levels of thiamine, niacin and iron!

### KELLOGG'S NEW INDIVIDUAL PACKAGE IS EASY TO USE 2 WAYS!

Just take the box in both hands and break open the top along the perforated line as shown. That's all there is to it! A perfect portion every time! (And for extra fun, eat right out of the package—just open the little perforated doors on the back of the box and pour the milk right on!) Either way, Kellogg's new Individual Box is CONVENIENT FOR YOU!

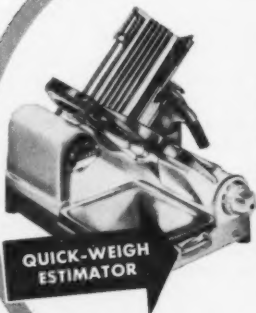


KELLOGG'S CORN FLAKES • RICE KRISPIES • PEP • KELLOGG'S 40% BRAN FLAKES • CORN-SOYA KRUMBLES • KELLOGG'S SHREDDED WHEAT • KELLOGG'S RAISIN BRAN FLAKES • ALL-BRAN

# Control Your Kitchen Costs

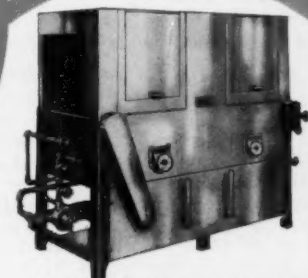
## WITH **TOLEDO**

### ALL THE WAY!



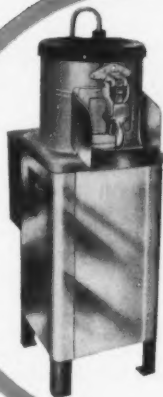
#### NEW SLICER WITH ESTIMATOR

The Toledo Quick-Weigh Estimator saves time, saves steps. Portions can be estimated right on the slicer. Illuminated platter . . . greatest ease of operation and cleaning . . . full choice of slice thicknesses up to  $\frac{3}{4}$ ".



#### FAST, EFFICIENT DISHWASHING

Toledo Conveyor-Type Dishwashers in full range of sizes and capacities. Automatic conveyor controls time of work for efficient dishwashing. Zip-Lok makes it easy to remove spray tubes for cleaning, without tools. Also available—Door-Type with 3-Way Door, opens front and both sides.



#### NEW "DOUBLE-ACTION" PEELER

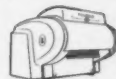
New Toledo Peeler for potatoes does a cleaner, faster job . . . with minimum of waste. Improved peel trap. Maximum adaptability to installation needs. Efficient Carborundum surfaces on both cylinder wall and disc. Choice of capacities—15, 30, 45 and 60 lb.—each peeling a full charge in 1 to 1  $\frac{1}{4}$  minutes.



#### AND THESE TOLEDOS, TOO!



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#### FACTORY-TRAINED SERVICE AS NEAR AS YOUR PHONE

Toledo sales and service offices in more than 200 cities ready to help you in the selection or maintenance of scales and kitchen machines.

**SEND FOR BULLETIN 1134**

# Safeguarding the Operating Suite—II

COL. R. A. PHELPS

Fort Snelling  
St. Paul, Minn.

THE only positive measure that can be taken against anesthetic gas explosions is to prohibit the use of gases which will form explosive mixtures with air or with any other gas used as an admixture. Extensive research is being conducted to discover an inert gas suitable for anesthesia. Until such a gas is available, great care must be taken in the use of other types of gases. The use of mixtures of these gases with air, oxygen or nitrous oxide, with the percentages controlled so as to fall outside the explosive range, is strongly recommended.

A very satisfactory anesthetic can be produced from a mixture of ethylene cyclopropane with oxygen which is nonflammable.<sup>1</sup> However, there is still danger in the use of this type of mixture as at the start and again at the tapering off of the process, the control of the percentages cannot be perfect and the resulting mixture may be explosive.

Inasmuch as at present, and for the foreseeable future, these explosive gases will be stored and used in the hospital, it is imperative that every precaution possible be taken to retain these gases under complete control and to prevent the ignition of the gases both in the anesthesia machines and in the areas where the gases are stored, transported or administered. These preventive measures can be classified under three general heads, the physical construction of the buildings, the types of furniture and equipment to be used, and the responsibility

ties of the personnel employed or present in the hazardous areas.

### PHYSICAL CONSTRUCTION

**Storage Rooms.** Great care must be taken in the storage of gas cylinders. Nitrous oxide and oxygen cylinders must not be stored in the same room with anesthetic gases. All cylinders not required for immediate use should be stored in rooms separated from and not communicating with the areas in which anesthesia is produced. It is highly recommended that these storage rooms be located in buildings separated from all structures that contain patients or clinical functions. These storage buildings should be constructed of fire resistant materials of a minimum rating of one hour.

Storage rooms must be well ventilated. Those used for the storage of combustible gases must be individually ventilated by gravity or mechanical means providing not less than two changes of air per hour. Air must be exhausted to the outside atmosphere in such location that the exhaust gases cannot reenter the building. Rooms used for storage of oxygen or nitrous oxide having in excess of 1500 cubic feet manifold (or cylinder) capacity must also be vented to the outside of the building.

All electrical switches, receptacles and lights shall be of the explosion-proof type meeting the requirements for Class I, Group C, Division I as specified in the National Electrical Code. All doors leading to storage rooms shall be marked, "Dangerous Gases. Keep Lights and Fires Away."

Small rooms used for temporary storage of spare cylinders or anesthesia

machines when not in use shall be constructed and ventilated as specified for general gas storage rooms, and shall be provided with conductive floors, if these rooms connect directly to the surgical or obstetrical suites.

Special attention is called to the absolute necessity of handling and storing used gas cylinders in the same manner as those that are fully charged. It is impossible to exhaust all of the gas from these cylinders in normal use. Therefore, there will remain a residue of the gas which is still dangerous. If storage facilities are not available these used cylinders may be stored in the open air, if removed from any location where escaping gas may form a hazard and if protected from mechanical damage.

Controlled heating in the storage rooms is also important. Filled cylinders which are held in readiness for immediate use should be stored in a temperature at or near that maintained in the anesthesia room. The control of the gas from a cylinder which is at a temperature differing from the surrounding atmosphere will be extremely difficult. Excessive heat is also dangerous as this will increase the pressure in the cylinders and may rupture the metal casing or the fittings.

The cylinders are very heavy and if they are allowed to fall the valves or bodies may be damaged. Therefore, the storage rooms should be provided with racks in which the cylinders can be securely fastened.

**Anesthesia Rooms.** Preventive measures should be taken in the construction of the operating rooms, delivery rooms, anesthesia rooms, and other areas where anesthesia apparatus is used. For sanitation the walls and floors in these areas must be of fairly

<sup>1</sup>Prof. J. W. Horton, Massachusetts Institute of Technology.

This is the second section of Col. Phelps' article on "Safeguarding the Operating Suite." The third section will appear in the January issue of this magazine.

*Specify*

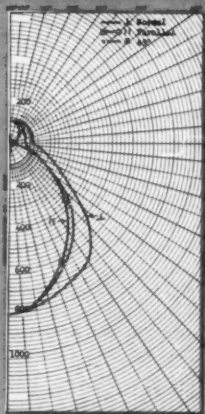
# FLEUR-O-LIER

## Coefficients of Utilization

LUMINAIRE DISTRIBUTION DATA									
MEAN VERTICAL									
Room height	Room width	Room depth	Room area	Room volume	Room shape	Room height	Room width	Room depth	Room area
10'	10'	10'	100	1000	1000	10'	10'	10'	100
12'	12'	12'	144	1728	1728	12'	12'	12'	144
14'	14'	14'	196	2744	2744	14'	14'	14'	196
16'	16'	16'	256	4096	4096	16'	16'	16'	256
18'	18'	18'	324	5832	5832	18'	18'	18'	324
20'	20'	20'	400	8000	8000	20'	20'	20'	400
22'	22'	22'	484	10648	10648	22'	22'	22'	484
24'	24'	24'	576	13824	13824	24'	24'	24'	576
26'	26'	26'	676	17576	17576	26'	26'	26'	676
28'	28'	28'	784	21952	21952	28'	28'	28'	784
30'	30'	30'	900	27000	27000	30'	30'	30'	900
32'	32'	32'	1024	32768	32768	32'	32'	32'	1024
34'	34'	34'	1156	39136	39136	34'	34'	34'	1156
36'	36'	36'	1296	46656	46656	36'	36'	36'	1296
38'	38'	38'	1444	55052	55052	38'	38'	38'	1444
40'	40'	40'	1600	64000	64000	40'	40'	40'	1600
42'	42'	42'	1764	73968	73968	42'	42'	42'	1764
44'	44'	44'	1936	84832	84832	44'	44'	44'	1936
46'	46'	46'	2116	96616	96616	46'	46'	46'	2116
48'	48'	48'	2304	109440	109440	48'	48'	48'	2304
50'	50'	50'	2500	123500	123500	50'	50'	50'	2500
52'	52'	52'	2704	138832	138832	52'	52'	52'	2704
54'	54'	54'	2916	155424	155424	54'	54'	54'	2916
56'	56'	56'	3136	173312	173312	56'	56'	56'	3136
58'	58'	58'	3364	192548	192548	58'	58'	58'	3364
60'	60'	60'	3600	213120	213120	60'	60'	60'	3600
62'	62'	62'	3844	235072	235072	62'	62'	62'	3844
64'	64'	64'	4096	258432	258432	64'	64'	64'	4096
66'	66'	66'	4356	283224	283224	66'	66'	66'	4356
68'	68'	68'	4624	309472	309472	68'	68'	68'	4624
70'	70'	70'	4900	337100	337100	70'	70'	70'	4900
72'	72'	72'	5184	366144	366144	72'	72'	72'	5184
74'	74'	74'	5476	396616	396616	74'	74'	74'	5476
76'	76'	76'	5776	428536	428536	76'	76'	76'	5776
78'	78'	78'	6084	461916	461916	78'	78'	78'	6084
80'	80'	80'	6400	496800	496800	80'	80'	80'	6400
82'	82'	82'	6724	533204	533204	82'	82'	82'	6724
84'	84'	84'	7056	571136	571136	84'	84'	84'	7056
86'	86'	86'	7396	610608	610608	86'	86'	86'	7396
88'	88'	88'	7744	651632	651632	88'	88'	88'	7744
90'	90'	90'	8100	694200	694200	90'	90'	90'	8100
92'	92'	92'	8464	738336	738336	92'	92'	92'	8464
94'	94'	94'	8836	784044	784044	94'	94'	94'	8836
96'	96'	96'	9216	831336	831336	96'	96'	96'	9216
98'	98'	98'	9604	880224	880224	98'	98'	98'	9604
100'	100'	100'	10000	930700	930700	100'	100'	100'	10000

These enable the specifier to select the proper unit for the job.

## CANDLEPOWER DISTRIBUTION



A complete photometric test of the luminaire is provided.



The Fleur-O-Lier label identifies units that meet precise specifications and are ETL certified.

## and know what lighting you'll get

It isn't necessary to *hope* you'll get satisfactory lighting from your fluorescent installation. Specify FLEUR-O-LIER equipment and you'll get these advantages:

1. FLEUR-O-LIER luminaires have been assigned a Fleur-O-Lier Index System rating by Electrical Testing Laboratories, Inc., after careful testing. This rating tells the exact illuminating characteristics of the unit. Complete photometric data and coefficients of utilization are provided.

### You know what you're getting

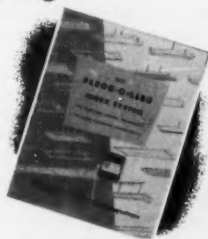
2. FLEUR-O-LIER luminaires are certified by ETL to assure they meet rigid specifications covering mechanical and electrical features. They all use CERTIFIED BALLASTS and CERTIFIED STARTERS.

### You know what you're getting

## Free Booklet

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Ask also for Electrical Testing Laboratories' report on performance ratings assigned to the 300 Fleur-O-Lier fixtures.



# FLEUR-O-LIER

*Manufacturers*

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hard, impervious materials which can be thoroughly cleaned. Masonry of some type is usually used for walls. Plaster with a hard, smooth finish, structural facing tile with a glazed surface, ceramic tile or pressed wood with an impervious surface are the commonest. All of these are nonconductive, and there is some danger of static generation or friction sparks from these surfaces. However, the danger in the walls is far less than that which exists in the floors and as the preventive measures which can be taken in floor construction will also protect the walls to a large extent, no special construction in the walls is considered necessary.

#### CONDUCTIVE MATERIAL ESSENTIAL

Practically all furniture and equipment and all persons, except the patient, within the hazardous area are in constant contact with the floor. The movement of persons and equipment across the floor is constantly generating static electricity. All types of standard floors, floor toppings and floor coverings are nonconductive or dielectric. This increases the static charges generated. It is, therefore, now made mandatory that all floors in operating rooms, anesthesia rooms, delivery rooms and in corridors, utility rooms, and sterilizing rooms immediately adjacent to and communicating with rooms where anesthetic gases are used, be constructed of conductive material. The code states that these floors must have a resistance of less than 500,000 ohms measured by two electrodes placed 3 feet apart at any point on the floor. To prevent electric shock, this resistance must be greater than 25,000 ohms.

The floors in these sterile areas must be smooth, impervious, nondusting and noncrumbling to allow for thorough cleaning. Ordinary floors of wood or concrete will not meet this requirement. Therefore, some type of covering or topping must be used. Coverings are materials applied to a completed floor. Toppings are integral parts of the floor itself, placed during the construction of the floor.

The usual floor coverings are mastic, linoleum, asphalt or rubber tile. Floor toppings are terrazzo, quarry tile and ceramic tile. As stated, the common types of all of these are dielectrics and very poor conductors, and as such will generate static electricity and will not allow the static charge generated on the floor itself, or in persons or

equipment in contact with the floor, to be carried away. Therefore, special construction is required in all of the hazardous areas where conductive floors are specified.

There are three methods of building conductivity into floors. The first is the overlay method which consists of inserting conductivity into floor coverings. This is accomplished by incorporating in the covering an admixture of conductivity material. A sufficient number of these particles are present to allow the static electric charge to pass from one to another and thus be dissipated throughout the entire floor covering, and be drained away where piping or other grounds are in contact with the covering.

Conductive coverings are now available in mastic, linoleum, asphaltic and rubber tiles. Mastic coverings were used extensively during the last war for floor covering in munitions factories. This material was quite soft and of a dark color and therefore not desirable for hospital use. I have been informed that later developments have produced a harder substance in lighter shades which is satisfactory. Such a material is highly desirable for remodeling existing hospitals as it can be laid over any type of existing floor. It is semifluid when applied and is troweled to a monolithic, smooth finish. The monolithic sheet allows the static electricity to pass at will in all directions, and as material flows around all pipes, good connections are made to these grounds.

Conductive linoleum is placed second to mastic as it is laid in large sheets with infrequent breaks in the electric paths at the joints. This material, as generally laid, has openings around piping, which will reduce grounding effects.

Asphalt and rubber tiles are supplied in small pieces, less than 1 foot square. The tiles are laid tightly together, but every joint is a possible break in the electrical path. These tiles also are generally laid with openings around the piping.

I believe that a safer and more satisfactory installation will be made when any type of floor covering is used if a mesh of fine conductive wire is laid between the covering and the under floor, this mesh to be connected to a permanent ground in several places. Such a mesh will provide an unbroken path to allow the static to be disseminated throughout the entire floor and drained away to the ground, thus

overcoming the open joint objections.

It must be cautioned that all of these coverings will wear much more rapidly than will masonry floors, and more frequent replacement will be required. There is also a question as to the life of the conductivity built into such coverings. Chemical action may, in time, reduce the contact between the conductive particles and thus greatly reduce the conductivity of the floor. Therefore, with these types of floor coverings frequent testing in the manner to be described later is mandatory.

The second type of conductive floor is the integral type. This is used in floor topping and therefore its use is limited to major alterations and new construction. This topping is a special terrazzo floor in which an admixture of conductive particles has been uniformly mixed. These particles are in relatively close contact and carry the static electricity throughout the floor. Thus it is dissipated and seeps away gradually through the masonry to some ground, such as the steel framework of the building or the piping system. Although not as important as in the case of floor coverings, it is still recommended that a wire mesh be used under this terrazzo, installed as has been described.

#### TWO TYPES AVAILABLE

Two types of this flooring are now available, one using copper oxychloride cement, and the other using carbon black made from acetylene. These admixtures provide a conductive surface throughout the entire floor area. Owing to the minute interruptions in the conductive paths, the resistance of these paths is high enough to meet the requirements. Some questions have arisen about the effect of time on the conductivity of this type of floor. It may be proved that chemical action will occur which will interrupt the electric paths through the floor at an increasing rate until the resistance will exceed the maximum allowed. The fact that these floors provide a hard, smooth, conductive surface makes them greatly desired, but they should be frequently tested to assure the retention of their conductivity.

The third type of conductive floor is the insert type. This consists of a grid of conductive metal strips inserted in the topping of the floor with the upper edges of the strips flush with the surface of the floor. This type can be used with terrazzo, quarry tile



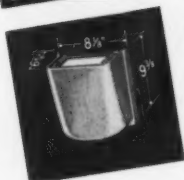
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or ceramic tile floors. The strips are placed at right angles forming 4 to 6 inch squares. They are soldered together and the grid thus formed is connected in several places to a permanent ground by a copper wire buried in the masonry. This type has been in use for a number of years and provides a positive ground for all objects or persons in electrical contact with the strips.

There are two objections to this type of flooring. It is obviously possible for equipment or persons to stand on this floor without being in contact with a strip and thus be unprotected. Also, when the electrical energy supplied to the area is from a grounded system, and a person in contact with a floor strip accidentally comes in contact with the ungrounded side of the electrical system, he will receive a tremendous shock, which might have serious effects on him or the patient on whom he may be working. This hazard also exists to a lesser degree for other types of grounded floors. It is to overcome these dangers that the code now requires ungrounded electrical circuits in all hazardous areas. This will be discussed later under electrical systems. With the use of this method, care must be exercised to assure that all fixed equipment is permanently attached to either the grid or a separate ground wire and that all portable equipment is in constant contact with the grid strips through the use of conductive casters, drag chains or other means.

To prevent shock it is recommended that when the insert type of flooring is used a fixed resistance of approximately 50,000 ohms be inserted between the ground wire and the permanent ground. This resistance should be placed in an acceptable location where it can be tested. In the surgical suite a very good location for these resistance units is in the equipment space provided for all recessed sterilizers. Cold water piping is available here for ground connections, and as entrance to this room should be restricted to service men only, there would be little danger of tampering with or damage to the units.

When the insert type of grounded floors is used the strips should be placed closer together across all openings leading from unprotected areas. This is to assure that all static charges carried by equipment or persons are drained away before entering the hazardous areas. Another good means of

protecting these openings is to provide plates connected to the ground at hand height on the jamb on the strike side of the doorway and on the door itself.

In existing buildings where no protection has been provided and funds are not available to provide any of the protective systems described, an inexpensive but far less satisfactory method may be used as a temporary expedient only. All fixed equipment can be intercoupled by wires placed along the walls and connected to a permanent ground. Personnel and portable equipment can be protected by portable cords attached to the unit or person and to the ground wire. These cords are cumbersome, obnoxious, and there is serious hazard of tripping or breaking contacts, but their use should be mandatory. A person in a relatively stationary position, as is the surgeon, may be protected by standing on mats of conductive material which are connected by wires to a ground.

The intercoupler method is not recommended by the code and should be employed only pending the installation of conductive flooring and other electrostatic safeguards, and the hazards involved in its use must be fully recognized.

**Electrical Supply Systems.** As has been mentioned, the use of grounded floors in the hazardous areas has increased the danger from electric shock from the normal electric supply circuits, if these are a part of a grounded electrical system. Therefore, the latest N.E.P.A. code specified that all electric supply systems serving the hazardous areas shall be of the ungrounded type. These supplies may originate from the building wiring system, from motor generator sets or from storage batteries.

The principal electric supply in most hospitals is alternating current furnished by public utilities companies. These supplies are generally grounded systems. That is, one wire of each circuit is connected to a permanent ground. Where this type of supply is used it is necessary to insert a break in the system to furnish the protected areas with ungrounded service. This is accomplished in the following manner. An insulating type of transformer is connected to the low voltage (not more than 300 volts) feeders supplying the area to be protected. This transformer is a dry type which can be placed in any convenient location

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outside the hazardous area. The primary winding of this transformer is connected to the building feeders and is protected and controlled as required for ordinary circuit protection. The neutral side of the primary circuit is grounded in the usual manner. The secondary wires from the transformer are not grounded and are provided with fuses or other over-current devices located outside of the hazardous area. These wires lead to a standard distribution panel or panels containing sufficient branch circuits to supply the entire needs of the area protected.

These panels should be placed in convenient locations near, but outside, the protected area. These should contain fuses or other circuit breaking devices for each branch circuit. All circuits feeding the area to be protected must be connected to these panels. Separate circuits should be provided for each of the principal rooms in the protected area.

In cases where the hospital electrical service is direct current with one side grounded, the insulation of the hazardous areas can be accomplished by the use of a motor generator or a

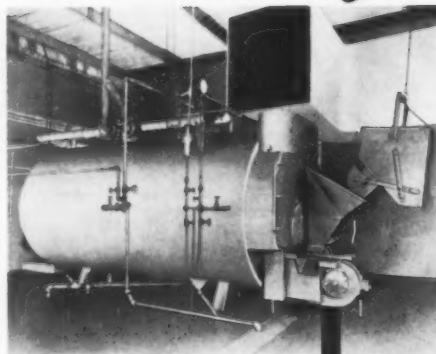
set of storage batteries located and connected in a manner similar to that specified for the insulating transformer.

As an added protection a ground indicator with signal lights is to be installed. Across the secondary leads from the insulating transformer (or direct current device) a resistor having not less than 10,000 ohms is to be connected. A relay is to be installed in a nonhazardous location with one lead of its winding connected to the midpoint of the resistor and the other to a permanent ground. A red and a green light and an audible signal are to be placed in a prominent location within the protected zone. The wiring for these shall be so connected that when no current flows through the relay the green light will burn. When a ground occurs on either side of the insulated circuit, current will flow through the relay, extinguishing the green light, lighting the red light and causing the audible signal to sound. Warning is thus given that a danger exists and immediate action is to be taken to find the source of the trouble, and to make the necessary repairs.

Regardless of the source of the electric current, whether from the building wiring system, from storage batteries, from standby generators or from special generators built into some types of equipment, the following rules governing the distribution systems are made mandatory by the National Electrical Code. All constant potential wiring shall be installed in grounded metal raceways, concealed in the building wall, ceiling or floors whenever possible. All outlets for connecting nonfixed equipment by cords or other detachable devices, when located within 5 feet of the floor shall be provided with explosionproof receptacles. These receptacles shall contain an integral switch and lock which prevents the attachment plug from being removed when the switch is in the "on" position. All wall and pendant types of switches when located within 5 feet of the floor shall have all electrical contacts fully enclosed in explosion-proof housings. All lamp bulbs shall be protected by substantial guards where exposed to breakage.

The code formerly set the danger zone as extending 7 feet above the floor. This caused much controversy especially concerning the main lighting unit over the operating table. To obtain sufficient illumination on the portion of the patient's body upon which the surgeon is working, it is

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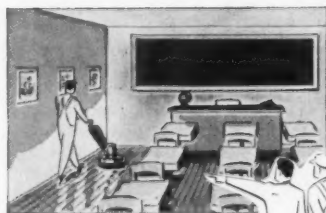
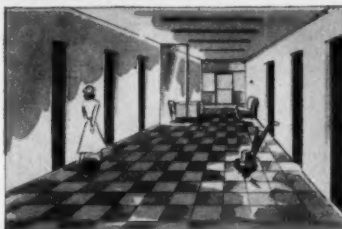
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- A church was my next stop. By this time I was looking for the Clarke name on all floor machines, but here they had only one Clarke and a machine of another make. Here again, I discovered something else about Clarke equipment. The custodian keeps a record of service and repair costs for both, and though the Clarke had run twice as many hours, its maintenance cost was much less.

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SEPT. 17-20, BOOTH NO. 231

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HILL-ROM COMPANY, INC., BATESVILLE, IND.

necessary that this light be adjustable as to position and have a means of concentrating the rays on a small area. These adjustments cannot be made unless the fixture is fitted with some type of moving contacts. The older models of these fixtures do not conform with the former code requirements. The revised code setting the limit at 5 feet allows most of these fixtures to be used if no sliding contacts, arcing or sparking parts can be moved into the 5 foot danger zone.

However, a change in the code does not alter the danger of the situation. It is agreed that the most dangerous concentrations of gases will be at or near the floor as the gases are heavier than air, but the air in the operating room is constantly in motion, particularly where forced ventilation or air conditioning is used, and therefore dangerous concentrations of gas may be forced above the 5 foot limit.

#### HAZARDS OF VIEWING BOXES

The built-in type of x-ray viewing box should be given special attention. I have visited operating rooms which had explosionproof electrical switches and receptacles throughout except on the viewing box. These had open light bulbs behind ill fitting glass fronts, controlled by common toggle switches. The code requires that these viewing box lights and switches be explosion-proof, unless the box is gas tight and the switches are located more than 5 feet from the floor.

Any other types of built-in cabinets or other equipment which contain electric lights or other electrical devices must be constructed in the same manner.

**Standby Electrical Units.** The use of "standby" electrical units to provide electric power for the operating suite in case of failure of the normal supply is highly recommended. These units, whether engine driven generators or storage batteries, must be located outside of the hazardous areas. The wiring system must be of the ungrounded type which has been described. All manual or automatic throw-over switches must be located outside of the protected area.

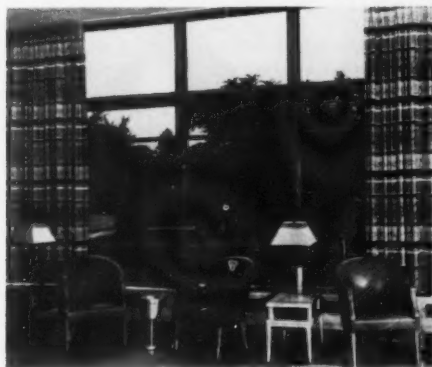
**Signal Systems.** The wiring for all signal systems, call systems, electric time systems, telephones and radio must conform to the same rules given for the main electrical supply system. Any equipment that is located within 5 feet of the floor must be explosion-proof.

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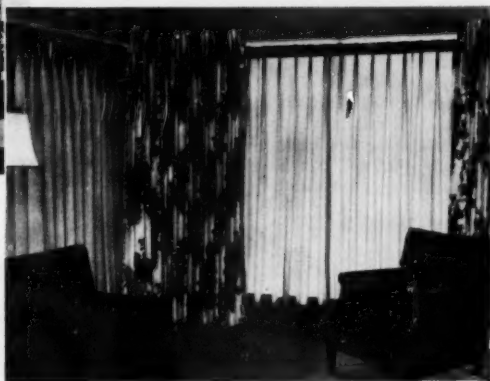


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## I Kept House for the Chronically Ill

**housekeeping in a chronic disease hospital presents some special problems and a challenge to the housekeeper**

THE duties of an executive housekeeper are basically the same whether she is working in a girls' school, a general hospital, or an institution for the chronically ill. That is, she is responsible for keeping the premises clean, the guests satisfied and happy, and the cost of maintenance at a minimum.

However, any housekeeper who undertakes to keep house for the chronically ill must learn to restudy her problem and organize her work accordingly. The frequent cleaning necessary in the chronic disease hospital, for example, requires the application of a far greater quantity of soap and water than is used in the general hospital. A thorough study of chemicals, the areas to be cleaned, types of flooring, and decorating problems will save the housekeeper many a headache in the long run and will preserve her hospital from abuse and damage.

### STUDY EACH AREA

It would be my suggestion that the housekeeper study for at least six weeks each area individually: its problems and medical program. (The allocation of floor space per square foot is no criterion for estimating the work to be done in a given area.) She should study the various types of patients, the treatment being rendered, the extent to which patients are incapacitated, their age, ability to cooperate, and their standard of living.

Much of the difference between the cleaning program in a chronic disease hospital and that of the general hospital lies in the fact that a large percentage of chronic patients are constantly in the hospital (no discharges so that the room can be stripped). The staff must learn to work around stretchers, wheel chairs and the ambulatory patients, as well as those who

are confined to their beds. Furthermore, the housekeeper must teach her employees to be aware of the needs of patients who are physically incapacitated and unable to help themselves.

There are, further, wide variations in the amount of work entailed in the cleaning of areas devoted to child patients, for example, as opposed to those in which aged women are housed. The latter do like to collect things and they are here for life, so their possessions accumulate. Also, it is possible to teach a child, whereas teaching a 90 year old invalid is a far more difficult task. It can be done, however.

There are many other factors to be considered: The type of building; location of toilets and bathing facilities; how patients are fed, i.e. in bed, on trays, sitting at tables. If the disease is communicable, an even more rigid cleaning technic must be followed. If patients in wheel chairs are permitted to leave the confines of the institution and go out on the city streets, the dusty roads of a country lane, or into a park, the cleaning problem will be increased. Stormy weather doubles the first-floor cleaning load.

Ramps and stairways must be policed constantly because they must be free of anything that might endanger a patient, such as water, flower petals, candy papers or dropped food. Porters must be taught to be forever aware that buckets, mops and brooms cannot be left around where they can cause accidents; that spilled water must be mopped up at once; that bathrooms must be cleaned as often as once an hour if necessary.

### MAE STARK

Executive Housekeeper  
Manhattan General Hospital  
New York City

If only the executive housekeeper were called in when the building was planned originally and could get her hands on the blueprints she could save the hospital thousands of dollars of maintenance costs by making suggestions that would result in reducing the labor force and still get the work done more efficiently and with higher standards of sanitation. If the housekeeper had her way, for example, urinals and commodes would be suspended from the walls and clear the floor by at least 12 inches; hopper closets would be large enough to permit the porter to walk inside, close the door, and do his work without cluttering up the corridors and messing the floors. In addition, all floor coverings that require constant polishing and buffing and those that are subject to rotting and mildew from constant washing would be eliminated. The floors in a chronic disease hospital, especially, should be of the type that can be maintained by damp mopping. Hours of labor time could be saved and the cost of maintenance reduced accordingly.

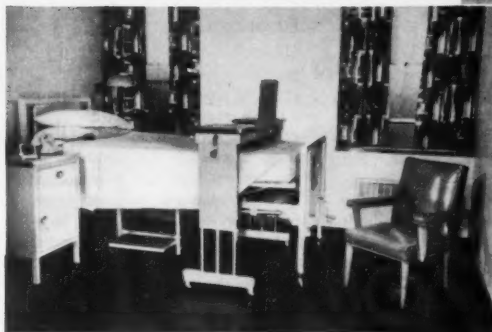
But apparently the housekeeper will never be considered in the planning and, as a result, must resign herself to laboring against odds and worrying about labor and replacement costs. And her problem mounts with the constant new demands of modern medical science.

### EMPLOYMENT

Intelligent housekeeping employees make for a smooth-running department, but the average housekeeper has

Miss Stark was formerly executive housekeeper of the Jewish Sanitarium and Hospital for Chronic Diseases, Brooklyn, N. Y.

## Corridors

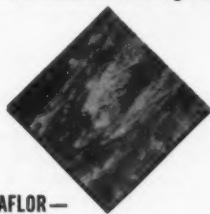


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found in the last 10 years that they are almost impossible to obtain. She takes what she can get and tries to instill into her crew some sense and a willingness to work and assume responsibility. Constant supervision is essential—the less intelligent employees are, the more supervision is required. The number of assistant housekeepers needed will vary with the number of patients, the amount of work to be done, and the number of porters and maids on the staff. On the average, a 200 bed hospital requires one assistant housekeeper; a 500 bed hospital, two; a 1000 bed hospital, three assistants and one chief porter. It is important for the executive housekeeper to have an office clerk so that she is free to leave her office and concentrate on supervising a given job until it is complete. This is particularly necessary while a renovation job is going on, a department is being moved, or when some emergency arises.

#### FIRE PREVENTION

Fire prevention in a chronic disease hospital is even more urgent than it is in a general hospital because so many of the patients are helpless. The housekeeping staff must be rigidly trained never to keep inflammable materials in hopper closets or to bring into the hospital any cleaning chemicals other than those issued by the executive housekeeper. Paints, lacquers, thinners and so on must be kept in a building outside the hospital proper.

Porters should be trained in both preventing fires and extinguishing any that do start. They should be taught to help remove patients from the building in case of a fire. As a rule, I demand that the porters accept instructions only from me, but in case of fire, doctors and nurses should give instructions regarding the removal of patients. Each charge nurse in a unit should issue orders until the engineer and his fire-fighters arrive. The housekeeper and her assistants must stand ready to render service wherever it is needed.

#### ICE SERVICE

In a great many hospitals the handling of ice is the responsibility of the housekeeping department. Ice should be transported in metal trucks on wheels (ball-bearing and quiet), and the person responsible for handling the ice should be taught the fundamentals of personal hygiene.

#### TRASH DISPOSAL

Trash should be kept in galvanized wheeled containers until it is ready to be disposed of in the incinerator. Once each day these cans—and the covers—should be steam washed. If the waste is infectious, the containers should be so marked and kept separate from the regular waste cans and washed on every removal.

#### CLEANING EQUIPMENT

Good equipment is expensive but in the long run it pays for itself. As much equipment as possible should be on wheels and so designed that it will move silently on rubber-tired ball-bearing wheels.

Only safe, tested chemicals and cleaning compounds should be used. As has been said, much more floor washing is needed in a chronic disease hospital than in a general duty hospital, and soap and water are a floor's worst enemies. Use soap sparingly.

Preferably, windows should be cleaned by professional contractors. The housekeeper who undertakes to have this work done by her own porters faces an insurance problem, and also the probability that the windows will be neglected because there is always some other job that is more important—so the windows wait!

#### LINENS

The control of linens has been discussed pro and con until it has literally been torn to shreds by hospital administrators the country over, who have as many ideas as there are hospitals. But they all do agree on one fundamental: "Have enough linen to take care of all patients' needs."

In my opinion, at least 20 per cent over and above the bed capacity is needed daily for incontinent patients. The linen should be delivered from the laundry to the floors by 7 or 8 a.m., whenever the hospital day starts. It should be kept under lock and key and

the key should be in the hands of the charge nurse. She should be responsible for seeing that there is an adequate supply for the next two shifts.

#### TEAM OF THREE

The executive housekeeper is in occasional contact with all of the patients in the hospital, but her porters and maids are constantly with them. Therefore, the housekeeper should encourage a friendly relationship between her employees and the patients, but should maintain constant supervision to prevent friction. The nursing staff occasionally needs help from the porters but all cleaning must be directed by the housekeeper.

In some cases it is necessary for porters to assist in removing patients from wheel chairs to their beds or into the baths. Often, the patients require some assistance in the toilets. Training as to when and how to lift patients should be given the attendants, but this type of work should not become a major part of the housekeeping employees' work.

Kindness to the patients must be the rule in the housekeeping department, and all employees must be extremely patient.

Much is expected of the executive housekeeper, and as time goes on the old "scrub-bucket-and-mop" job performed by an elderly matron in a gingham apron is giving way to scientific maintenance under the guidance of a highly trained professional person. More education will be required of the executive housekeeper to fit her for her increasingly important position.

As the doctor is responsible to his patients and his profession, so the housekeeper is responsible to the patients and management. She must be trustworthy, honest and willing to give of herself. She must work with both the nursing and professional staffs and with her own maintenance group and still keep all contacts friendly, impersonal and on a high professional level.

If she knows where she is going and states her principles honestly to her employees, the staff will stand by her and help her to meet any emergency. The housekeeper who does not have the allegiance of her staff is beaten before she starts. She must know her job, her hospital, her patients and her employees. When she has accomplished this, the rest is easy.





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*Moving Problem?*



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Ruggedly built of  $\frac{7}{8}$ ", 18 gauge cold rolled, welded steel tubing. 3" rubber, ball bearing, swivel casters. Overall dimensions: Height  $36\frac{3}{4}$ ", Length 27", Width  $18\frac{3}{4}$ ". Available with solid aluminum or wire baskets.

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**WILL ROSS, INC.** MILWAUKEE 12, WISCONSIN

## NO PANIC—NO CASUALTIES

(Continued From Page 60)

nex there might have been panic. The rushing around of firemen and the cascade of water which finally found its way down the annex stairwell might well have started panic had the patients remained. As it turned out, there was no real need to evacuate the hospital completely. The annex

was untouched except for water and a little smoke. The point that may be made here is that it would be well for the hospitals of a community to have a general understanding as a group with the local fire department about total evacuation, depending, of course, on the construction and

situation of each hospital in that community. The fire chief should have (and does have) the power to remove patients at will. None of us would like to have to make the decision that he must. But it is also true that total evacuation should be avoided wherever possible.

This is probably the best place to say without any equivocation that the Dallas fire department is to be complimented unreservedly on the superior way in which it fought the fire and brought it under control with such consummate skill. We are proud of our fire department. We learned at the very least one thing more. We learned that if total evacuation is ordered a system must be devised to care in an orderly and careful way for the patients evacuated as they leave the building. We learned, too, to our great relief that the police department had taken care of this aspect of the evacuation by having immediately available a fleet of ambulances, taxis and buses to transport our patients out of the cold night air to other hospitals or to their homes or to homes in the neighborhood which offered hospitality.

The police department is most dependable, but we now feel there would be more security for our patients if we actively planned a system of harboring the harborless. We can be grateful that we know how it is done now. Of course there are many things learned that are difficult to classify; the experience has been invaluable to us. We hope that it will prove valuable to others.

A "cornette" is the white head-piece of the religious habit that the Daughters of Charity of St. Vincent de Paul wear. It is the symbol to the patients new and old of St. Paul's Hospital of the good care and watchfulness given by the Sisters. Here were 20 additional regular supervisors immediately available to assist our fine nurses. This was a most important asset in the fire. There can be no questioning the fact that one of the most stabilizing and quieting influences on the patients during the fire was the appearance in every corridor, and outside on the street with the patients, of the white cornette. And to them must go the credit of making the fire safety program work on October 24. Thank God for all things, but especially that He spared the Sisters who in turn directed the rescue and saved so many lives.



GENESEE COUNTY SANITARIUM, FLINT, MICHIGAN

Architects: Malcomson, Fowler & Hammond, Inc., Detroit. Plumbing Contractor: Miller-Davis Co., Kalamazoo. Kohler Distributor: A. P. Englehart Co., Flint.



Greenwich Lavatory K-1950-F; Bardon Urinal K-4977; Penryn Siphon Jet Closet K-3858-ET (Left) Bradley Surgeon's Lavatory with Niedeecken knee control and gooseneck spout K-12702-A

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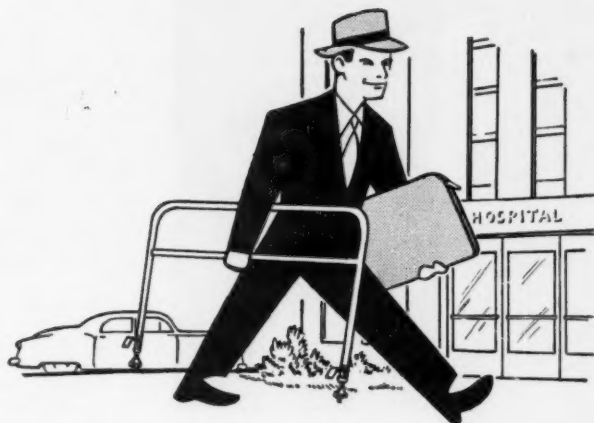
Shown are some of the fixtures in the new Genesee County Sanitarium, Flint, Michigan, which provides 163 beds for tubercular patients.

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This man is your hospital supply dealer's salesman! He has a vast amount of information about new products... information that he gathers from many sources, many manufacturers.

This trip he's carrying a **HARD** product. He's thinking of helping you solve a safety problem. However, he could just as well be carrying a new forceps... or an improved sutures... or a more efficient detergent.

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"Savings more than justify price."

\*Hospital sources of above statements on request.

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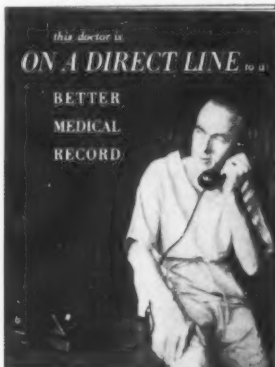
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Thomas A. Edison  
INCORPORATED

## AMBROISE PARÉ

(Continued From Page 80)

reply. Not long after, Aug. 28, 1590, the siege ended. A few months later, Dec. 20, 1590, Paré died.

For many years this great surgeon of his time was practically forgotten. Centuries later came a revival of interest in his great deeds and in 1812 the Medical Society of Bordeaux erected a bronze statue, designed by the artist David, at Laval.

Paré was definitely the man of his time, a great light in the darkness of bigotry and dogmatism. Intolerant of the bonds of scholastic tradition, he boldly stood against the medical authorities who refused to recognize this offspring of the people. His contribution to hospital progress was his determined elevation of surgery and surgeons out of the slough of ignorance and the promotion of surgical practice based upon scientific observance and practice.<sup>2</sup>

### "FATHER OF FRENCH SURGERY"

The history of Paré "demonstrates in the first place the power of ambition and genius over obscurity of birth, poverty and defective education; and, second, the rewards which follow a life of virtue and of steady devotion to one particular pursuit. . . . No man ever worked harder than he with an eye more single to the advancement and honor of the profession which he so ardently loved. . . . His toils and his fidelity, continued through a period of upwards of sixty years, have earned for him a conspicuous niche in the temple of fame, and the glorious title accorded him by the common consent of posterity, of the 'Father of French Surgery.'"<sup>1</sup>

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The Roosevelt Hospital  
in Mid-Manhattan



One of Roosevelt Hospital's  
ambulances in action - a familiar  
scene around New York.

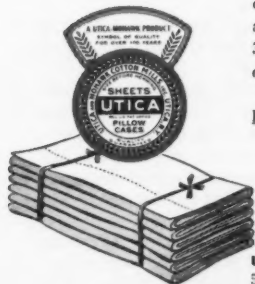
## Hospital in Action

The Roosevelt Hospital's ambulance district includes the greater part of midtown Manhattan, the most active and most densely populated area in New York. The ambulance answered 7,947 calls last year; 36,621 people came to the Hospital for emergency care.

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## THE ROUND TABLE

(Continued From Page 83)

ing that nursing leaders have difficulty trying to come up with uniform plans of any kind when hospital situations vary so from community to community and from state to state?

MR. JONES: Do you think most hospitals today are making as great an effort as they should to help increase the supply of practical nurses and to increase the supply of trained nurse's

aides, so as to turn over more and more bedside duties to these lesser professional people and relieve professional nurses to do real, professional, skilled nursing?

MISS ERICKSON: All communities and all nursing groups are not yet ready to receive practical nurses. Our community at the present time is offering under a community advisory council representing nurses and doctors a review course for practical nurses. Those are all experienced practical nurses and they will be licensed pretty soon, and yet our hospital does not

recognize a practical nurse as such, and the courses are being given in our hospital! In our town the practical nurses and the graduate nurses are nowhere near harmony. You couldn't do much to promote practical nursing in our town at this particular time.

MISS MORGAN: Do you think that the registration of the practical nurse in the state of Illinois is going to break down a lot of the feeling toward practical nurses?

MISS ERICKSON: It will break down the opposition of the graduate registered nurses of the 1900 era, when nurses were first licensed and had to go through a period of proving that you have to have an education to become a nurse. The practical nurses are going to have to live through the same kind of thing.

MISS MORGAN: Where are you getting your greatest opposition to practical nurses? From what particular group of people?

MISS ERICKSON: I was talking about the nursing group itself.

MISS MORGAN: Would it be a matter of education of the nursing group to make them see that there are positions for all types of nurses if they are all licensed and all go through proper courses?

MISS ERICKSON: That's the point. They have not all gone through the proper courses. At the present time they are going to have to accept practical nurses who have come up through the ranks, who have taken their training as they came. When the time comes that the practical nurses are all graduates of some school of nursing, the situation will be different. In the interim, we are going to have tension between the practical nurses on one hand and the graduate nurses on the other.

MR. JONES: Do you have any trouble at Wesley in using practical nurses?

MR. HUESTON: We have no practical nurses.

MR. JONES: You have nurse's aides.

MR. HUESTON: Yes, but no practical nurses.

MR. JONES: Do you have no practical nurses because you can't get them or because you don't want them?

MR. HUESTON: We have our own training program for our own nurse's aides. We have the ward helper, who is recruited in groups of 16 and oriented over a period of eight hours a day, five days, or 40 hours of professional instruction. At the end of

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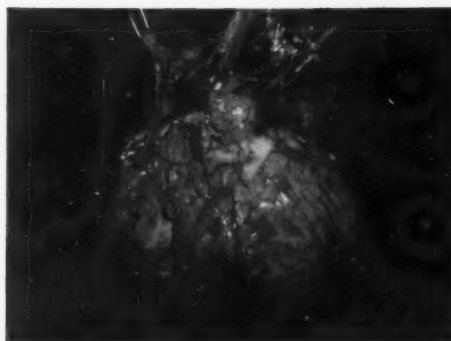
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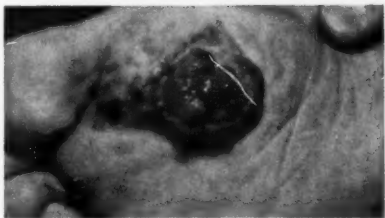
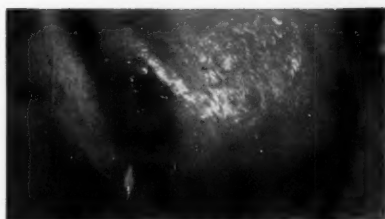
ECHINOCOCCUS CYST (Four aspects): In making these transparencies, glistening highlights were maintained through use of unfrosted bulbs; main lighting unit was used to provide maximum delineation of specimen; fill-in illumination was used to soften shadows. Backgrounds were transilluminated glass. (Ektachrome transparencies.)

## Picture the patient

*in color . . . to show it as the eye saw it*

WITH PHOTOGRAPHY rapidly becoming a "must" in hospitals, clinics, and private offices, more and more physicians are insisting upon the use of color film for recording all significant cases. Color, they feel, "sees" as they themselves see. With color, they can present records with minimum explanation and maximum assurance that associates will see each case as they themselves saw it.

Is additional equipment necessary for color work? The answer is "No" in most instances. In fact, here's all that's actually needed: a camera with color-corrected lens . . . a reliable light source . . . a suitable Kodak color film—Ektachrome, Ektachrome, or Kodachrome.



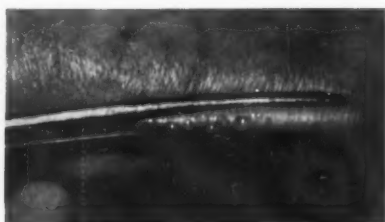
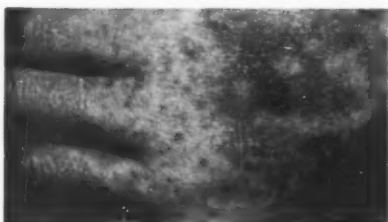
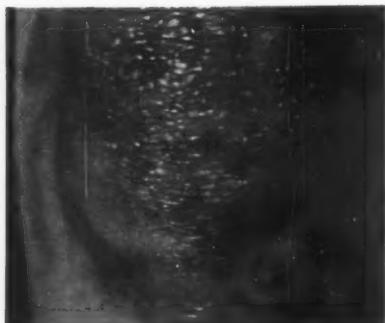
EXTREME CLOSE-UPS: Addison's disease (tongue). Malignant melanoma (sole of foot). Both illustrations made with hand-held 35mm. camera. Supplementary lens and focal frame used. (Kodachrome transparencies.)

(See over the page.)

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## Picture the patient (continued)



**PINTA:** Selections from a teaching series. Note how effectively changes in skin color are depicted (erythema of various shades, depigmentation and hyperpigmentation), as well as changes in the structure of the skin (atrophy). Illustration at lower right shows method of obtaining serum for dark-field examination. The pictures were made with a hand-held 35mm. camera, supplementary lens, and focal frame. Illumination: flash bulb. (Kodachrome transparencies.)

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In its widely distributed leaflet No. 268, "Eat a Good Breakfast," the U.S. Dept. of Agriculture states: "Summer or winter, there's something hot, as a rule, in a good breakfast. . . . Something hot is cheering and tones up the whole digestive route."



The problem of encouraging children to eat an adequately protective breakfast finds easier solution when Ovaltine in hot milk is recommended as a breakfast beverage. Many children clamor for a hot drink at the morning meal, and hot Ovaltine is the right kind of drink to recommend.

A cup of hot Ovaltine makes an excellent contribution of virtually all essential nutrients, adding substantially to the nutritional start for the day. It also serves in a gustatory capacity by enhancing the appeal of breakfast and making other foods more inviting.

The nutrient contribution made by a cup of Ovaltine is apparent from the table below. Note the wealth of essentials added to the nutritional intake by making the simple recommendation of adding a cup of hot Ovaltine to the child's breakfast.

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½ oz. of Ovaltine and 8 fl. oz. of whole milk,\* provides:

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FAT . . . . .	10.5 Gm.
CARBOHYDRATE . . . . .	22 Gm.
CALCIUM . . . . .	370 mg.
PHOSPHORUS . . . . .	315 mg.

IRON . . . . .	4 mg.
COPPER . . . . .	0.2 mg.
VITAMIN A . . . . .	1000 I.U.
VITAMIN B <sub>1</sub> . . . . .	0.39 mg.
RIBOFLAVIN . . . . .	0.7 mg.

NIACIN . . . . .	2.3 mg.
VITAMIN C . . . . .	10 mg.
VITAMIN D . . . . .	140 I.U.
CALORIES . . . . .	225

\*Based on average reported values for milk.

that she is put on the ward. If at the end of one week's time she has indicated that she has an aptitude to go further, then she is given an opportunity to participate in 50 additional hours of on-the-job training. On completion of that her title is changed to nurse's aide and she gets a different type of a uniform and an increase in salary.

MISS MORGAN: And the education? Is she educated further than she was originally?

MR. HUESTON: The two programs include 90 hours of total training.

MR. JONES: Do you think the nurses on your staff have any fundamental objections to practical nurses?

MR. HUESTON: I can't speak for them.

MR. JONES: I know that in many parts of the East practical nurses are accepted as a matter of course. The patients get better care and the graduate nurses have time to smile and be nice to the patients.

MISS ERICKSON: I am intrigued with Miss Montag's theory of providing nursing service through a "nursing technician" who would have two years

of training in a community college and 450 hours of hospital experience. Miss Montag makes the point that nursing is a continuous program, that on one hand you have the simple technics that you can teach to aid homemakers and mothers, and on the other hand you have the professional duties that a professional nurse must do, and between the two you have a wide range of technical skills. She suggests that we should provide for nursing technicians who would be something less than three-year graduates and something more than practical nurses. In her book, "Education for Nursing Technicians," she outlines the course, and I have been very much intrigued as I read about that, because to my way of thinking it would create a better hospital situation to have nursing technicians and professional nurses than to have ward helpers, nurse's aides, practical nurses and graduate nurses and degree nurses.

MR. JONES: Trying to cut down the number of titles in the nursing department so that people won't get too confused?

MISS MORGAN: I think that many of Miss Montag's views are good, but I think it is rather unfortunate that she chose the name "technician," because it seems to imply something scientific and detracts from the human side of nursing that we need to think of.

MISS ERICKSON: I don't think the title nursing technician is any worse than practical nurse.

MR. JONES: In the minds of many people the term technician connotes a laboratory operator with no concern for the human being, whereas a nurse, whether it is a practical nurse or a registered nurse, is supposed to have some consideration for the human being and be interested in people. Certainly in the whole nursing service setup, we have to tap as high a percentage of womanpower at all age levels and educational levels as is humanly possible if we are going to keep hospitals operating and take care of patients. What you call them and at what levels of training you work it out are immaterial compared to the importance of tapping all the womanpower you can.

MISS ERICKSON: Except that we have to be in accord with the prevailing pattern.

MR. JONES: What do you mean by the prevailing pattern?

MISS ERICKSON: The prevailing pat-



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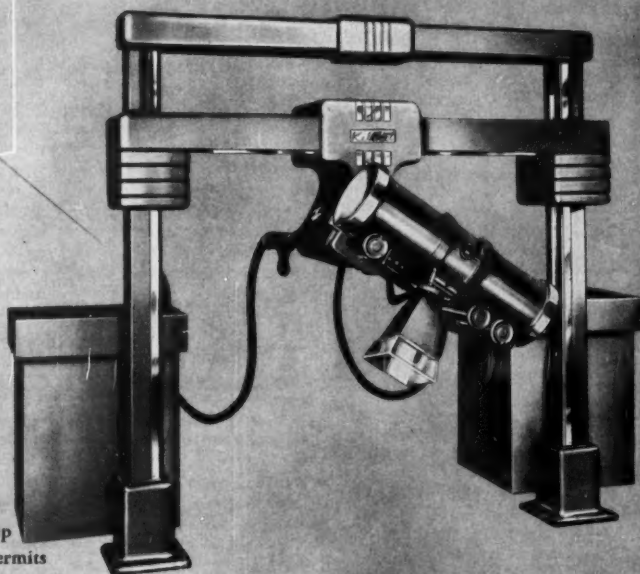
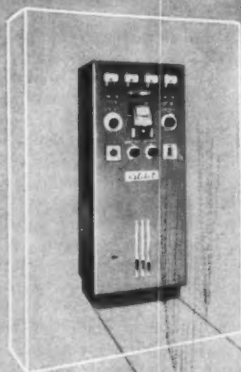
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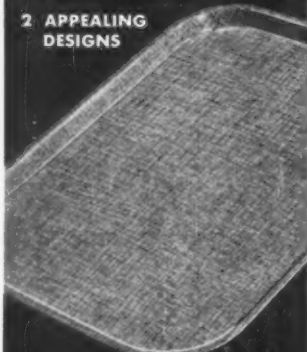
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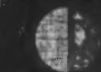


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tern at the present time is practical nurses, nurse's aides, graduate nurses and degree nurses. Now try and instill into that particular picture a new concept of an entirely new person, and you run up against a resistance to change, even before you have a chance to try it. I think maybe that is one reason we haven't got any further with our studies of nursing procedures and techniques.

MISS MORGAN: Prevailing patterns also imply standards.

MR. JONES: It is interesting that a number of hospitals have been experimenting with practical nurses or highly trained nurse's aides actually in the operating room as circulating nurses and scrub nurses.

MISS MORGAN: They used operating room technicians during the war—experienced corpsmen. At the present time there is a tremendous scarcity of operating room nurses in all hospitals, and so it was necessary for us, in order to open our new operating rooms, to look for some other type of personnel that we might train to put into those situations.

MR. JONES: Are they high school graduates?

MISS MORGAN: No, they aren't. I have taken them from the vocational schools for practical nurses here, because I wanted someone who had some conception of what hospital work is like, so that those preliminaries would be over with before we would start the program.

MR. JONES: Had those girls actually had their diplomas from the practical nurse school when you took them?

MISS MORGAN: Yes.

MR. JONES: How long did you have to train them before you put them in the operating room?

MISS MORGAN: We start them right off in the operating room, but the whole length of their training period is three months.

MR. JONES: Then do they actually act as scrub nurses and circulating nurses?

MISS MORGAN: Only for minor scrubs. They are circulating nurses, mainly.

MISS ERICKSON: I talked to the civilian instructor of the Camp Carson Army Center, Colorado Springs, who is teaching surgical technicians for the army about the program they have, and I was interested in it. They actually teach these people to be scrub nurses and circulating technicians. They teach them some of the funda-

mentals of anatomy and some of the fundamentals of bacteriology, and they go through a rather rigid course. I asked this civilian instructor, "What do you think about the idea of general hospitals beginning to adopt this particular pattern?" He felt there was a possibility of this becoming a little more widespread.

MR. JONES: I suspect the civilian hospitals can learn a lot from the armed forces' condensed, streamlined teaching programs. They make some fine operating room people and good ward corpsmen in a very short time.

MISS MORGAN: The city of New York has really gone ahead largely with this type of program.

MISS ERICKSON: Won't there be some effect on the relating of duties in the army release made public recently about the fact that the graduate nurses do not have to do this, this, and this duty which they were assigned to before and now they can be assigned to other people?

MR. JONES: In World War I, the registered nurses were acting almost entirely as head nurses, and practically every bit of patient care was done by medical corpsmen. We didn't have any three years of training, and we apparently did a pretty good job!

MISS MORGAN: That was maintained during the last war, was it not?

MR. JONES: Even more so, in the last war.

MISS ERICKSON: At the National League of Nursing Education meeting in Boston this year the theme was nursing service, and they had an exceptionally fine presentation on the use of human resources and a particularly good description of the handling of a very difficult patient—with a little bit of coaching on human relations. One of the most promising things in our society today is the scientific study of human relationships.

MR. JONES: I think it is encouraging that in the hospital field we are beginning to hear more and more talk about just that. At convention programs and institutes, and in our university programs in hospital administration, you are beginning to see a rapid increase in the attention being paid to this business of understanding people and helping people, and not just obscuring ourselves in the technicalities of science and management.

MISS ERICKSON: Isn't it strange that we have to go back to that! Where did we lose it—that now we have to go back and get it?

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## A.D.A. Convention

(Continued From Page 116)

physician, lost 70 pounds in about 10 months. Appetite control was achieved through the diet because the dieters learned to eat foods which provided high nourishment for their calories.

The diet imposes few restrictions. Salt intake is merely reduced. Coffee or tea, unsweetened, may be included in amounts recommended by the doctor, utilizing part of the diet's milk allotment. Meats may be prepared in any way desired, including frying. Drippings, including fat, may be used to season vegetables.

Dr. Ohlson's associate, Dr. Dena C. Cederquist, reported a second phase of the experiment designed to test the effectiveness of a reduction diet low in carbohydrate in which more than half of the 1500 calories were derived from dietary fat. In college age women weight losses averaged 1½ pounds per week for a period of 16 weeks.

More or less directly concerned with the problem of overweight were the remarks of Dr. Iago Galdton of the New York Academy of Medicine. Said he, "People eat because they are hungry, jealous, envious, frustrated . . . not because of a basic interest in diet." Man is not a rational animal, only "schizophrenics, professors of philosophy, Communists and sick people" are really rational, he asserted. From the psychiatrist's point of view, the normal, healthy person is only interested in achieving his goals. Nutrition education like all health education rests on the false assumption that man is primarily a rational animal, and that the best way to influence his behavior is to appeal to his reason, that man is primarily interested in health, and that man is interested in eating for health. These are naive and corrupting assumptions. The truth is that life is not logical—it is biological. Therefore, the basic training of the nutritionist should include instruction in dynamic psychology, particularly as it bears on motivation, Dr. Galdston stated. The nutritionist is called upon to exercise skills, to operate in a field studded with obstacles and mined with hidden, explosive potentials. In this field, caution and the skills of purposive indirection are essential for effectiveness.

Dr. Charlotte G. Babcock, of the Chicago Institute for Psychoanalysis,

said that overt and concealed anxieties are often factors which interfere in the orderly acquiring of food habit changes appropriate to the nutritional need. Knowledge of the patient's problem in the situation demanding change in relation to food, skill in the recognition and management of his anxiety about or his resistance to change, and appreciation of the patient as a person as well as his dietary needs in the first and subsequent interviews facilitate his nutritional care. Failure to understand the goals, emotional inertia, inability to resist internal demands or external pressure are among the factors that may interfere with the patient's conscious wish to follow the prescribed dietary regime.

### INSUFFICIENCY A PROBLEM

The underfed rather than the overfed concerned Robert R. Williams, chairman, Fund for Combat of Dietary Diseases. India's prime problem is insufficient food, Mr. Williams explained. She shares, however, with all Asian countries the need for greater variety. Along the entire populous Bengal coast rice makes up 80 per cent of the caloric intake. In the north and extreme south the rice is all parboiled, which conserves important amounts of vitamins and minerals. North of Madras about 20 million people, and smaller groups elsewhere, insist on white rice. Indians, Burmans and Thai share the bad practice of cooking rice in an excess of water which is usually discarded. In the rest of Asia only enough water is used to be fully absorbed by the rice.

Incidentally, an illuminated display in one of the convention's commercial exhibits, its data supported by well-documented evidence, graphically showed the effect of high and low protein diets upon the peoples of four countries: Australia, the United States, China and India. The first, with a protein intake (69 per cent from animal sources) of slightly more than 113 gms. per capita per day, showed an average adult population height of 5 feet 8 inches with a life expectancy of 65 years. In descending scale India, with an average protein intake about half that of Australia and only 16 per cent animal in its source, showed an average height of 5 feet 4 inches and life expectancy at 27 years!

As Dr. Howard B. Lewis, University of Michigan, stated in his review of 50 years' study of the rôle of protein, despite the vitamins, the minerals and

the enzymes, Mulder's concept of 50 years ago is still valid. The proteins are still "first" and today, more than ever, high protein diets are the rule in medical practice.

Continuing further with the protein story, Dr. Wm. J. Dieckmann, University of Chicago School of Medicine, said there is a definite correlation between a protein intake of 85 grams or more and the absence of abortion, less anemia of pregnancy, and a higher per cent of excellent babies as graded by a pediatrician. He believes that the high protein diet ordinarily consumed by his patients in early pregnancy is evidence that a high protein intake was also consumed before conception. The incidence of anemia was lower in those on a high protein intake, but there was no statistical correlation between the level of protein intake and the following: toxemia of pregnancy, duration of labor, fetal abnormalities, lactation, premature delivery, and stillbirth and neonatal mortality.

Incoming officers of the association include: president, Dr. Margaret A. Ohlson, University of Michigan; president-elect, Beulah Hunzicker, Presbyterian Hospital, Chicago; speaker of the house of delegates, Dr. Helen L. Gillum, California; secretary, Marguerite L. Pettee, University of Colorado; treasurer and chairman of finance committee, LeVelle Wood, Ohio State University.

At the annual dinner, the Lydia J. Roberts Essay Award offering a yearly grant of \$500 for the best essay on a subject chosen from the field of the history of nutrition was announced. At the same meeting the annual Marjorie Hulsizer Copher Award, the highest honor bestowed by the association, was presented by Dr. Lillian Storms Coover, retiring president, to Lenna Francis Cooper, for many years chief dietitian at Montefiore Hospital, New York City. Miss Cooper's citation read in part: "Pioneer in the American Dietetic Association, the first to propose its formation, co-founder and chairman of the first national conference of dietitians . . . first vice president chronologically and fourteenth president. . . . Her determined and courageous spirit, while always sensitive to the needs of others, has ever held to the highest purposes."

With a total registration approaching 3000, the meeting closed with plans under way for the 1952 convention in Minneapolis.



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# NEWS DIGEST

**"Matching Plan" for Internships Modified . . . A.H.A. Names Members to Joint Board . . . Medical Civil Defense Leaders Meet . . . Dr. Ivy Suspended by Medical Society . . . Colorado, Oklahoma, Kansas and Illinois Meeting Reports**

## Committee Modifies "Matching Plan" for Hospital Internship Appointments

CHICAGO.—A modification of the "matching plan" for internship appointments was announced here last month by the National Inter-Association Committee on Internships, following a committee meeting at which objections to the plan were studied.

The committee defended the matching plan as one which is fair to both students and hospitals and said the modifications were largely procedural, in line with suggestions made by medical students.

"A national poll taken of the opinion of students leads the committee to believe that a substantial majority of all senior medical students favors a matching plan for internship placement but prefers the procedural details known as the 'Boston Pool' plan," a committee statement issued following the meeting declared. "Student representatives of three national medical student organizations contributed to the committee deliberations and all agreed that the revised procedure is a desirable improvement."

The matching plan, with the indicated changes, was outlined as follows in the committee report:

1. The student submits a rank order list of his preference for the hospitals to which he has applied. (No change.)
2. The hospital rates the students who have applied to it, ranking in order the applicants in each of its groups, 1, 2, 3 and 5, those it does not want. (No change.)
3. The students are then arranged in rank order according to the hospital evaluation. One student will appear on as many hospital lists as there are hospitals to which he has applied. (No change except detailed ranking was permissive before but is now required.)
4. The students rated in the No. 1, or most preferred, group by the hospitals that rank that student as their first choice are immediately and permanently placed in that hospital. (No change.)

5. Such student names are removed from the list of the other hospitals lower on their list to which they have also applied. (No change.)

6. The remaining names on the hospital list are then advanced in order and the top ones are tentatively placed in the accepted group to fill the vacancies. This procedure continues. A man cannot be passed by a person below him on a hospital preference list; he advances on that list only as a man ahead of him is removed because of having been placed in a hospital higher on that student's preference list. A man interns at the hospital highest on his preference list which offers him a place.

The changed procedure assures "al-

most universal student support" of the matching plan, the committee stated. "Even those small groups which do not approve of all the details and which would prefer an open hunting season are willing to abide by the wishes of the majority of students," the committee said.

The plan can work only by cooperation of students and hospitals, Dean F. J. Mullin of Chicago Medical College, chairman of the committee, warned. "Good faith on the part of everyone is necessary," he stated. "Approved hospitals have shown a generous willingness to cooperate fully. The committee invites the full support of both groups to this modified procedure which we believe corrects virtually all valid objections to the previously proposed procedure."

## Chicago Blue Cross Plan To Include Subscribers in Southern Illinois

CHICAGO.—Group Hospital Service, Inc., of St. Louis will discontinue operations in southern Illinois, effective Feb. 29, 1952, and has requested the Blue Cross Plan for Hospital Care, with headquarters in Chicago to assume responsibility for the 100,000 members in that

area, it was reported here November 19. Arrangements have been completed between St. Louis and the Blue Cross Plan for Hospital Care to offer membership in the Illinois plan to all members, both group and direct pay, residing in Illinois who now hold membership in the St. Louis plan, according to Robert T. Evans, executive director of the Illinois plan.

## A.H.A. Names Hatfield, Wilinsky, Hummel, Rourke, Crosby, Healy to Joint Board

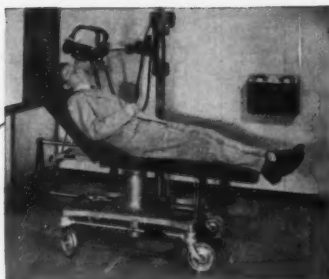
CHICAGO.—Members of the newly organized Joint Commission on Hospital Accreditation have been appointed as follows by the participating organizations, it was announced here last month:

American Hospital Association: John N. Hatfield, Philadelphia, and Dr. Charles F. Wilinsky, Boston, to serve for one year; Stuart K. Hummel, Joliet, Ill., and Dr. Anthony J. J. Rourke, San Francisco, to serve two years; Dr. Edwin L. Crosby, Baltimore, and Rt. Rev. Msgr. John J. Healy, Little Rock, Ark., three years.

American College of Surgeons: Dr. Newell W. Philpott, Montreal, one year; Dr. Frederick A. Collier, Ann Arbor, Mich., two years; Dr. Arthur W. Allen, Boston, three years.

American College of Physicians: Dr. Alexander M. Burgess, Providence, R.I., one year; Dr. William S. Middleton, Madison, Wis., two years, and Dr. Leroy H. Sloan, Chicago, three years.

Six representatives of the American Medical Association have been chosen, it was reported, but announcement of their names was awaiting their acceptances and approval of the appointments by the association's house of delegates at the interim session at Los Angeles this month.



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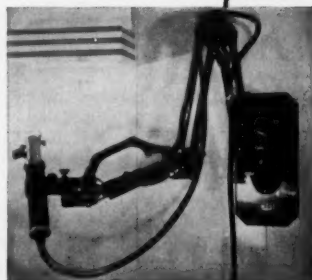
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## NEWS...

### Public Health, Hospital Leaders Attend Medical Civil Defense Meeting

CHICAGO. — A closer relationship among hospitals, physicians and public health authorities was the objective of a conference on medical civil defense held here last month under the joint sponsorship of the American Medical Association, American Hospital Association, and Association of State and Territorial Health Officers. The objective was named in an opening address by Dr. James C. Sargent of Milwaukee, chairman of the A.M.A. Council on National Emergency Service.

#### AIMED AT CLOSER TIE-UP

"Planning and arrangement of the conference program are aimed at inspiring a much closer tie-up in the health aspects of civil defense between the authority of the health commissioner, the facilities of hospitals, and the working manpower of physicians and their many allies in the care of the sick and injured," Dr. Sargent stated. "While there are areas in which this important inter-relation has already developed, by and large across the nation this is one of the crying needs of civil defense today."

Representing the hospital group, Anthony W. Eckert, administrator of the Perth Amboy Hospital at Perth Amboy, N.J., described the disaster planning which made it possible for that hospital to provide effective care for more than 100 victims of the Pennsylvania Railroad wreck at Woodbridge, N.J., last February. "A flexible plan of operation and well oriented personnel are the only reliable allies in meeting totally unexpected and extremely heavy demands," Mr. Eckert stated. "How can any community justify prolonged ignorance of its total resources or delay in preparing a plan which demands exacting coordination of all agencies when the stakes are so high?" Mr. Eckert asked. "Civil defense is the way to save lives," he declared.

F. Wilson Keller, president of the New York State Hospital Association, took part with medical and public health representatives in a panel discussion on organizing and equipping improvised hospitals in a civil defense emergency. The panel addressed itself to such subjects as the use of household equipment for improvised hospitals, collection methods for equipment and supplies, the recruitment, organization and train-

ing of housekeeping and maintenance personnel, and the use of existing hospital facilities in an extended hospital system.

Summarizing the medical civil defense problem, Dr. Norvin C. Kiefer of Washington, director of the health division of the Federal Civil Defense Administration, said an enemy attack in event of war might result in a possible 3,000,000 civilian casualties. Two-thirds of these casualties would survive the first 24 hours, Dr. Kiefer estimated. "Our hospital plans are based on the assumption that about two-thirds of surviving casualties would need hospital care," he added. "One-third would need extensive, and the other third only moderate or short-time, hospital care."

Civilian casualties would place a heavy strain on blood supplies, Dr. John B. Alsever, consultant on blood therapy to the F.C.D.A., told the conference. During the first days following an enemy attack there could be no dependence on normal procedures in grouping, typing, and cross-matching blood, Dr. Alsever stated. Consequently, he said, "there will be general use of type 'O' blood, which can be given with almost complete safety to anyone without cross-matching." He urged that selective blood grouping programs be carried out in critical target areas.

More than 250 representatives of state hospital and medical associations and public health departments attended the conference.

### Blue Shield Enrollment Reaches 21,000,000

CHICAGO.—Twenty-one million people in the United States and Canada have been enrolled in Blue Shield plans, according to a recent announcement by the Blue Shield Commission. The 21 millionth subscriber was Rosemarie Hart of St. Paul, a Northwest Airlines stewardess, who became a member of the Northwest Airlines group in the Minnesota Blue Shield plan. Frank E. Smith, director of the Blue Shield Commission, presented Miss Hart with a certificate in commemoration of the event, at a ceremony that was held in St. Paul recently.

Minnesota Blue Shield announced that its own enrollment has reached the 500,000 mark.

### Colorado Speaker Urges Hospitals to Explain Needs for Essential Materials

DENVER. — H. E. Rice, business manager of the Porter Hospital, Denver, was named president-elect of the Colorado Hospital Association at the 27th annual meeting of the association here last month. Mr. Rice will succeed Henry E. Hill, administrator of the Weld County Hospital at Greeley, who became president during the meeting. Louis Liswood, president of the National Jewish Hospital here, was the retiring president.

Hospitals must explain their needs for essential scarce materials such as steel, aluminum and copper in detail in order to get priority consideration from national defense needs, Charles



Colorado officers (l. to r.): Robert A. Pontow, President-Elect H. E. Rice, Henry E. Hill, M. A. Moritz.

Brokaw, regional director of N.P.A., told the association. The government wants to take care of hospital needs but is dependent on hospitals for information required to support priority demands, he said.

"We have had cases where hospital authorities were disgruntled over turn-downs that shouldn't have happened, provided they had told us just why they needed what they wanted. Applications come in a flood, and 50 per cent of our rejections are merely because the application doesn't carry documents explaining its essentiality." Members of the association heard and took part in discussions of hospitals and civil defense, hospital auxiliaries, medical staff problems, and food service.

In addition to Mr. Rice other officers elected by the association were: vice president, Sister Mary Line of Glocker-Penrose Hospital, Colorado Springs; treasurer, M. A. Moritz of Denver General Hospital, and executive secretary, Robert A. Pontow of Colorado General Hospital.



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## NEWS...

### **300 Attend Oklahoma Meeting; Celeste K. Kemler Named President-Elect**

TULSA, OKLA. — Celeste K. Kemler, administrator of the Valley View Hospital, was named president-elect of the Oklahoma State Hospital Association at the 32d annual convention here last month. Miss Kemler will succeed Harry C. Smith, administrator of Wesley Hospital at Oklahoma City, who became president during the meeting.

In an opening general session devoted to financial problems of hospitals, the convention heard an address on "The Indigent Care Dollar," by Kenneth Wallace, business manager of the University Hospitals at Oklahoma City and president of the Midwest Hospital Association. Other speakers at this session were N. D. Helland, executive director of Oklahoma Blue Cross, and Leonard P. Goudy, assistant director of the American Hospital Association, who spoke on economies in hospital operation.

In addition to general sessions, the convention presented section meetings for operating room supervisors, pharmacists, medical record librarians, housekeepers, and hospital dietitians.

### **Armour H. Evans To Head Kansas Hospital Group**

TOPEKA, KAN.—Armour H. Evans, superintendent of Wesley Hospital at Wichita, was named president-elect of the Kansas Hospital Association at the 37th annual convention here last month. Mr. Evans will succeed Bruce W. Dickson, Bethany Hospital, Kansas City, who became president during the meeting.

Subjects discussed during the two-day session included hospital nursing service and nursing education, auxiliary activities, and hospital safety. Albert V. Whitehall, director of the Washington Service Bureau of the American Hospital Association, addressed the convention on national trends affecting hospital operations and policies.

In addition to Mr. Evans, other officers elected for the coming year were: vice president, Sister M. Aloisia of Pittsburgh; treasurer, Carl C. Lamley of Topeka; trustee, R. A. Molgrem, El Dorado; Charles B. Newell and Sister Rose Irene were named delegate and alternate to the A.H.A.

Attendance at the meeting totaled 279. The 1952 meeting is scheduled



Seated, left, J. P. Cox and, right, Harry C. Smith, the new president. Standing (l. to r.): N. D. Helland, Kenneth Wallace, and Leonard P. Goudy.

Other officers elected by the association to serve for the coming year were: vice president, Sister Mary Agatha, St. John's Hospital, Tulsa; secretary, Cleveland Rogers, Junior League Children's Hospital, Tulsa, and treasurer, Sister Mary Fidelise, Blackwell General Hospital, Blackwell. J. P. Cox, administrator of Oklahoma Baptist Hospital and Margaret Lamb of the Norman Municipal Hospital, Norman, were named delegate and alternate to the American Hospital Association. More than 300 hospital people from throughout the state were registered for the convention.

to be held November 6 and 7 at Kansas City, it was reported.

### **Hospital Rates Go Up From 8 to 10 per cent in 1951**

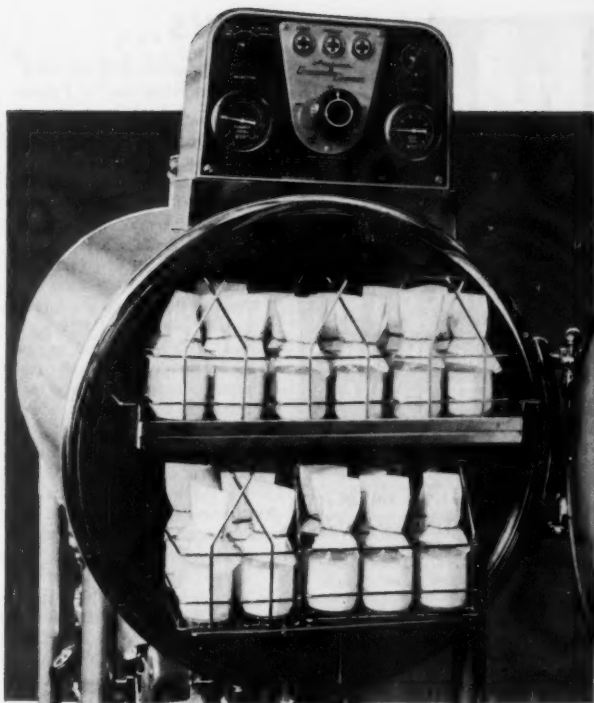
CHICAGO. — Hospital room rates increased from 8 to 10 per cent in the last year, the fifth annual hospital rate survey conducted by the American Hospital Association indicated. Results of the survey were published here last month in a report entitled, "Hospital Rates—1951."

The average rate for single person rooms increased 8.5 per cent from 1950 to 1951 and 32 per cent from 1947 to 1951, the survey revealed. Two-person room charges rose 8.82 per cent in 1950-51, and rooms accommodating more than two persons showed recent increases of 10 per cent, it was reported.

Rates in Pacific and New England states are higher than the national average, the survey indicated. Increased charges for special services were also reported from all sections of the country. The survey was based on reports coming from 3300 general hospitals.



IN THIS PRESSURE-TYPE STERILIZER, a welded, forged end ring of solid Monel is welded to the inner Monel chamber shell. Since no rivets are used, this construction provides an easy-to-clean, crevice-free, smooth sterilizing chamber. The formula trays are also made of solid Monel—to assure long, trouble-free performance.



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**H**ERE'S A HINT—don't count the bottles! Look at the milk formula sterilizer itself.

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**NEWS...**

**Kellogg Gives \$89,615 to  
Western Reserve to Train  
Nursing Administrators**

CLEVELAND.—The sum of \$89,615 from the W. K. Kellogg Foundation has been granted to the Frances Payne Bolton School of Nursing at Western Reserve University to be earmarked for a special graduate level program to train administrators of hospital nursing services.

Western Reserve is the only Ohio institution involved in Kellogg's new five-year program devoted to development of educational programs designed to improve the administration of nursing services in hospitals throughout the country.

Dr. Helen L. Bunge, dean of the nursing school at Western Reserve, has outlined a three-fold plan which includes development of a program of instruction for nurses who wish to qualify for administrative posts; provision of workshops, institutes and conferences to assist those concerned with nursing service problems, and creation of a center for the study of nursing administration problems and for consultation service to hospitals.

The planned programs at Western Reserve emphasize in-service training as well as pre-service work on the academic level.

**N. Y. Municipal Hospitals  
Test Air Raid Defenses**

NEW YORK.—Bed patients in municipal hospitals here were moved away from window areas and covered with blankets, and ambulatory patients were conducted to shelter areas in a civil defense air raid drill conducted by New York's civil defense organization last month.

Hospital superintendents, nursing executives, physicians with civil defense assignments and other workers were alerted by confidential signal when the drill began. Following the "all clear" signal 45 minutes later, disaster teams were assigned to emergency stations and carried out their duties with "emergency patients."

Patients and hospital staff were notified in advance that the drill was to be conducted, so that there would be no interference with patient care while it was going on, Director Arthur W. Wallander of the city's civil defense organization said.

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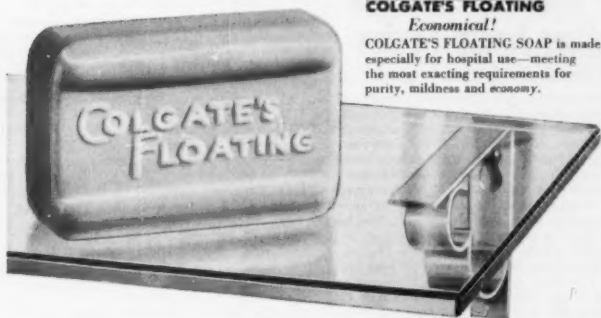
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## NEWS...

### Medical Society Suspends Dr. Ivy in Controversy Over Cancer Remedy

CHICAGO.—Dr. Andrew C. Ivy, vice president in charge of professional schools at the University of Illinois, was suspended from membership in the Chicago Medical Society for three months for "unethical conduct" in connection with his introduction last spring of krebiozen, a new cancer treatment, it was announced here last month.

The society's action was taken after careful consideration of the "methods employed in promoting a substance known as krebiozen in the treatment of cancer," a statement issued by the medical society indicated. The society objected to the fact that Dr. Ivy introduced the new cancer treatment at a meeting of physicians, newspaper reporters, and magazine writers before

it had been reported in scientific literature, it was explained; also, krebiozen was said to be a "secret remedy," since the exact process by which it is developed has not been disclosed.

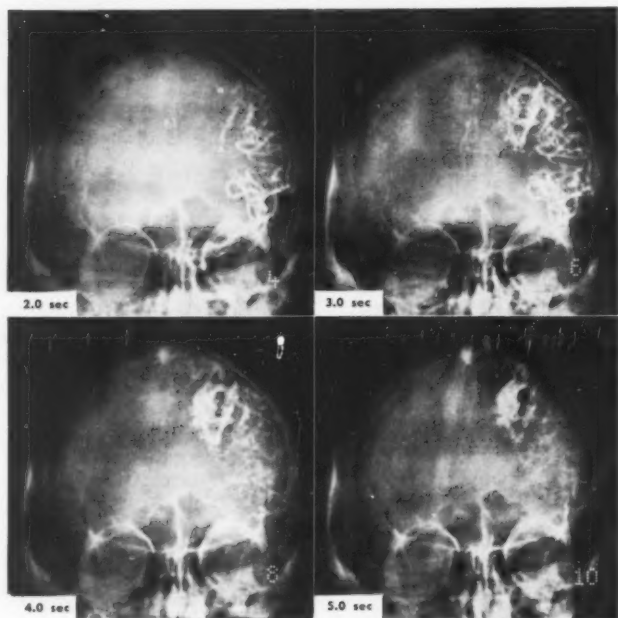
Dr. Ivy denied that he was guilty of any breach of medical ethics but said he did not intend to appeal the society's decision. He will continue his research with the new treatment, he stated, even though an American Medical Association report on krebiozen last October labeled the drug practically worthless as a cancer agent.

In his own defense, Dr. Ivy said krebiozen was not a secret remedy. "The spirit of the ethic against a secret remedy is to prevent a physician from attracting patients and making money by saying he has a secret remedy," Dr. Ivy stated. "I explained that in the case of krebiozen the drug had been given without charge during our investigation. No one has made any money or attempted to attract patients."

Speaking for the Chicago Medical Society, Dr. H. Kenneth Scatliff, president, said the case had been considered by the society's cancer committee and council, and by the ethical relations committee. "The cancer committee and the council felt it was regrettable that Dr. Ivy would associate himself with a drug whose physical and chemical properties were kept a secret," he said. Dr. Scatliff added that the society had attempted to prevent Dr. Ivy's activities in connection with the investigation of krebiozen from arousing false hopes in cancer victims.

Stating that he intended to continue his studies with the drug and was preparing an independent report of its effects in the treatment of 500 patients, Dr. Ivy said he would not protest his suspension. "No one believes more than I do in the principles of medical ethics and their just interpretation and enforcement," Dr. Ivy told newspaper reporters. "Regardless of the majority decision of the council of the society, I am not guilty of a breach of medical ethics. However, I shall not appeal and shall continue investigation of the merits of krebiozen."

In its formal statement issued following the council meeting at which action against Dr. Ivy was taken, the society said it had "exerted unusual care and diligence before making its

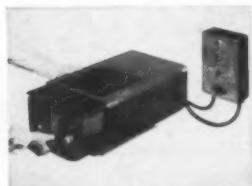


**ARTERIOVENOUS ANGIOMA.** Films made at half-second intervals after percutaneous injection of 10 cc. of 35 percent Diadrast solution into left internal carotid artery.

(Courtesy Neurological Institute of New York)

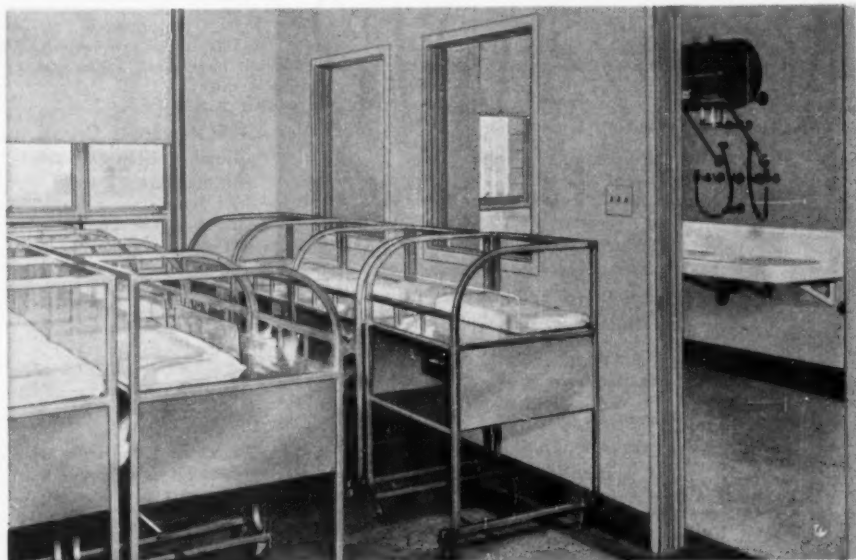
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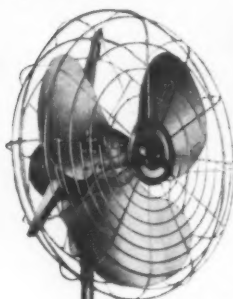
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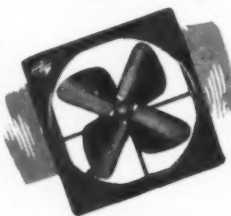


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## NEWS...

decision," because of Dr. Ivy's world-wide reputation as a physiologist, medical investigator, teacher and administrator.

### A.P.H.A. Urges Creation of Federal Health Department

SAN FRANCISCO. — Creation of a federal department of health under a medical administrator of cabinet rank was urged in a resolution adopted here last month at the annual meeting of the American Public Health Association. The association also recommended transfer of health activities now carried on by the Federal Bureau of Indian Affairs to the U.S. Public Health Service and asked for further developments of full-time public health services in local areas.

Dr. Wilton L. Halverson, state health commissioner for California, was named president-elect of the association for the coming year. Dr. Halverson will succeed Dr. Gaylord W. Anderson, director of the school of public health at the University of Minnesota, who became president during the meeting.

In his address as out-going president, Dr. William P. Shepard said some factions in organized medicine were trying to limit the activities of public health officials. These factions tend to confuse the public health programs with what they call "socialized medicine," Dr. Shepard charged. "The public health profession has occasionally been beset by a few physicians who appear to fail to see the reasons for public health and whose influence at one time or another becomes sufficient to impede seriously the important objective of the health department," Dr. Shepard stated.

Dr. Edward J. Godfrey Jr., formerly commissioner of health for New York State, was awarded the Sedgwick Memorial Medal for distinguished service in the field of public health.

### Hits Overuse of Antibiotics

NEW YORK. — Antibiotic drugs are frequently used unnecessarily — sometimes with harmful results, Col. Edwin J. Pulaski of the Army Medical Corps stated at the state meeting of the International College of Surgeons here last month. Col. Pulaski reported that one hospital indicated 40 per cent of its pharmacy bill was for antibiotics. Overuse of antibiotics increases the growth of resistant strains of diseased organisms, he said.

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## NEWS...

### Milwaukee Hospitals to Consolidate Fund Campaigns, Report Reveals

MILWAUKEE.—Hospitals here have consolidated their planning and fund-raising efforts in a unified long-term program, the Milwaukee Hospital Council reported last month. The unified plan resulted from a survey of Milwaukee County hospitals and hospital needs conducted by the council's Commission for Coordinated Hospital Planning, it was indicated.

The commission has recommended that all the general hospitals refrain from individual fund-raising drives and cooperate on a five-year consolidated campaign aimed at raising \$6,500,000 to provide the estimated 400 new hospital beds recommended by the commission.

If individual hospital boards agree to cooperate with the program, the fund-raising program will get under way immediately, it was indicated.

The \$6,500,000 to be raised in the

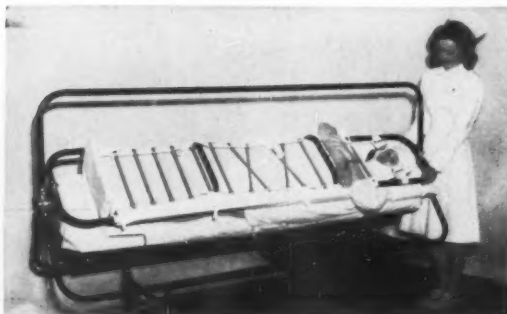
consolidated drive will be allocated as follows among the Milwaukee hospitals, the commission said:

1. \$1,000,000 to Mount Sinai to add 40 beds; \$200,000 is on hand.
2. \$1,160,000 to Deaconess for 87 beds; no funds on hand for building.
3. \$2,140,000 for a new 197 bed St. Francis hospital; \$1,100,000 is on hand.
4. \$1,600,000 for St. Michael's to build a new 170 bed hospital; \$1,000,000 is on hand.
5. \$400,000 for Milwaukee Hospital for 40 beds; it has \$800,000 on hand.



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### Religion and Health Journal Scheduled for Publication

DURHAM, N. C.—A new monthly magazine designed to "bridge the gap between religion and medicine" will appear in February 1952, Russell L. Dicks of the Divinity School faculty at Duke University here announced last month. The new journal will appear monthly under the title, *Religion and Health*, Dr. Dicks said.

"The problems of health are basically the problems of religion," Dr. Dicks explained in describing the functions of the forthcoming publication. "With the human body and human mind so constructed as to go on functioning almost indefinitely without becoming sick, why then do we become ill? We become ill because of the wear and tear of emotional tension on the body. Emotional tension is the disease of this generation. The magazine *Religion and Health* will bring resources of religion and psychology to bear upon the problems of health."

Dr. Dicks will be editor of the new publication, it was announced. Articles scheduled to appear in the first issue of the magazine cover such subjects as child training, heart disease, guilt, alcoholism and the healing effects of love, the announcement said.

### C. S. for Venetian Blinds

WASHINGTON, D. C. — The new commercial standard for venetian blinds has been announced by the Commodity Standards Division of the U. S. Department of Commerce here. The standard is No. CS61-51, the division said, and resulted from studies and acceptances by producers, distributors, and users of wood-slat venetian blinds.



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## NEWS...

### Women's Auxiliary Holds Special Session at Meeting of Illinois Hospital Group

SPRINGFIELD, ILL.—A feature of the meeting of the Illinois Hospital Association and Conference of Women's Hospital Auxiliaries here November 15 and 16 was a special all-day session of the auxiliaries which was attended by approximately 100 representatives. In addressing this group, Elizabeth M. Sanborn, secretary, American Hospital Association Committee on Women's Hos-

pital Auxiliaries, cited a number of case histories indicating the wide scope of help which can be given to hospitals by their women's auxiliaries. One interesting case involved the provision by the auxiliary of badly needed parking facilities for hospital employees, doctors and visitors. "Providing these parking facilities did a great deal for the public relations of the hospital in question," Miss Sanborn pointed out.

Auxiliary members must have a full understanding of just what the hospi-

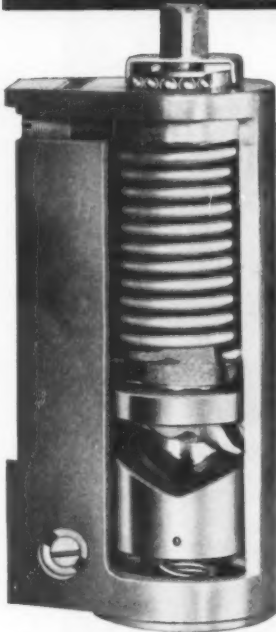
tal's job is in the community before they take any action, E. W. Jones, vice president of The Modern Hospital Publishing Company, warned. He discussed the difficult financial problem faced by voluntary hospitals in caring for indigent patients at a great loss. The auxiliary members were told they could be a powerful force in correcting this situation if they knew all the facts. Mr. Jones also pointed out that members of the auxiliary should not attempt to defend so-called high hospital costs but should be prepared with all the facts so that they could discuss the situation intelligently.

At the opening meeting of the Illinois Hospital Association Elmer E. Abrahamson, attorney and secretary-treasurer of the Norwegian American Hospital, Chicago, asserted that the old doctrine of immunity of charitable organizations against damage suits is being breached all over this country. He warned hospitals to carry adequate malpractice and general liability insurance. In the discussion following Mr. Abrahamson's talk, the question was asked whether hospitals carrying liability insurance might invite liability suits. The consensus of the entire group was that this is not a danger and every hospital has a moral responsibility to protect its patients, visitors and staff through adequate insurance coverage.

In addressing the hospital association group, Mr. Jones expressed the opinion that even with the most favorable set of circumstances, including the best available consulting help, the average hospital could not reduce its operating expenses per patient day by more than 5 per cent. He said the most important job facing the hospital team is how to reduce the patient's bill through a shorter stay and the elimination of unnecessary treatments and procedures.

Thursday morning's nursing session evoked a lively discussion of what practical nurses can and cannot do for a patient. Naomi Murphy, R.N., superintendent of nurses, Carle Memorial Hospital, Urbana, explained that 80 per cent of all patient care was being given by practical nurses in some nursing units of the hospital. A statement was made that practical nurses should be able to compute dosages and give any kind of medication. This assertion did not bring out the expected argument but was approved by nurses and administrators alike.

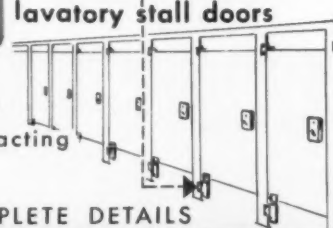
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CAN WIN**



**\$500**  
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To celebrate our 25th Anniversary we are conducting a search for the oldest floor, rug or carpet machine that is still in regular use. Your old machine may be the winner! Enter it NOW, subject to Rules of Contest:

1. Any make or model of floor, rug or carpet scrubbing machine is eligible for prizes if it is currently in regular use, daily or weekly.
2. To determine the age of any machine entered in this contest, the serial number will be submitted to the manufacturer, and the date assigned by him accepted.
3. A first prize of \$300 will be awarded for the oldest floor machine. In addition, eight consolation prizes of \$25 each will be awarded for the eight next oldest.
4. All entries must be postmarked no later than Nov. 30, 1952. Prizes will be awarded on Dec. 15, 1952.
5. Duplicate prizes will be awarded in case of ties.



1927-1952

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**25<sup>th</sup>**

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Here is our entry in the Hild Contest.

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## NEWS...

pital payment agreement with the Illinois Public Aid Commission, James Gersonde, executive secretary of the Illinois Hospital Association, said the information supplied by 108 Illinois hospitals about their losses in caring for indigent patients was the greatest single factor in convincing officials of the Illinois Public Aid Commission, the Illinois Department of Welfare, and individual legislators that adequate payments must be made to hospitals for the care of indigents. Several persons pointed out that as Blue Cross and Blue Shield coverage increases, the number of medical indigents will decrease.

The annual banquet was distinguished by its lack of a head table and the introduction of guests, as well as the lack of after dinner speeches.

An unscheduled but pleasant feature of the banquet was the presentation to Florence S. Hyde of a substantial gift on the occasion of her retirement



Florence S. Hyde

from work in the association. Mrs. Hyde, who was further honored at the business meeting the next day by election as an honorary member of the state association, will devote her full time as a hospital public relations counselor.

More than 300 hospital administrators, department heads, trustees and women's auxiliary members registered for the meetings. Erwin W. Wegge, business manager of the Moline Public Hospital, Moline, took office as president, succeeding Leslie Reid, superintendent, Presbyterian Hospital, Chicago. The following officers were elected: president-elect, George H. Van Dusen, administrator of the Christian Welfare Hospital, East St. Louis; first vice president, Russell H. Duncan, administrator, Carle Memorial Hospital, Urbana; second vice president, the Rev. John Weishar, diocesan director of health and hospitals, Peoria; secretary-treasurer, Wendell H. Carlson, administrator, Englewood Hospital, Chicago. New trustees elected include: Leo Lyons, St. Luke's Hospital, Chicago; Stuart Hummel, Silver Cross Hospital, Joliet; Leonard W. Hamblin, Deaconess Hospital, Freeport; Veronica Miller, Henrotin Hospital, Chicago. Delegates to the A.H.A. are Leslie Reid and Erwin Wegge; alternates, Veronica Miller and Eva H. Erickson.

## Darnell Casters

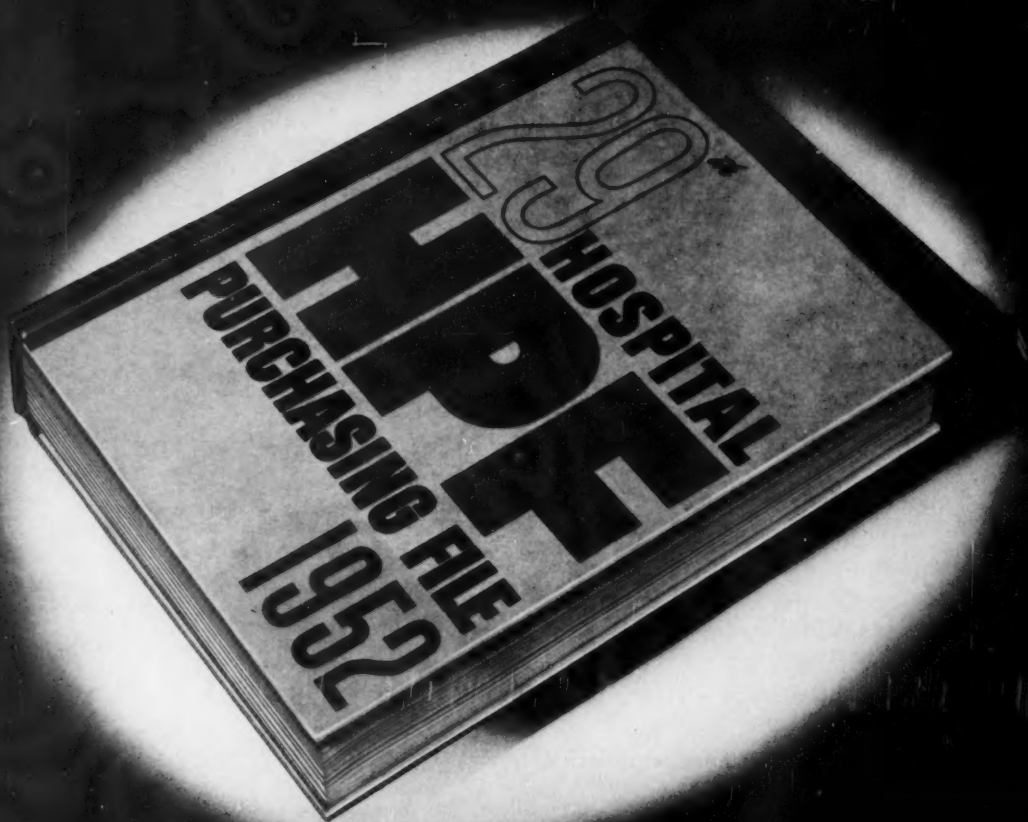


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# 29

NOW the new 29th Edition of Hospital Purchasing File is coming from the bindery and going into the mails. Its classified list of hospital products has been thoroughly revised and brought up to date. About 800 pages of manufacturers' catalogs are more descriptive and more detailed than ever before. Its reference section has been completely revamped for greater utility. Your copy will reach you shortly. Look for it. Use it. Be sure your department heads learn to use it for detailed product data. Published by Purchasing Files, Inc.

ESTABLISHED AS THE HOSPITAL YEAR BOOK IN 1919 BY THE MODERN HOSPITAL PUBLISHING CO. INC.

# THE BUSINESS SIDE ►►►

Don't forget that Hospital Purchasing File has a lot of excellent catalog information on business machines and office equipment—modern devices to make the administrative function easier and more efficient. Turn to section A in the copy on your desk. Also, be sure to familiarize yourself with section H for information about suppliers of products and special professional services, consultants and fund-raising organizations. Section H includes things that can not be exactly cataloged, but it's information you want at your fingertips.

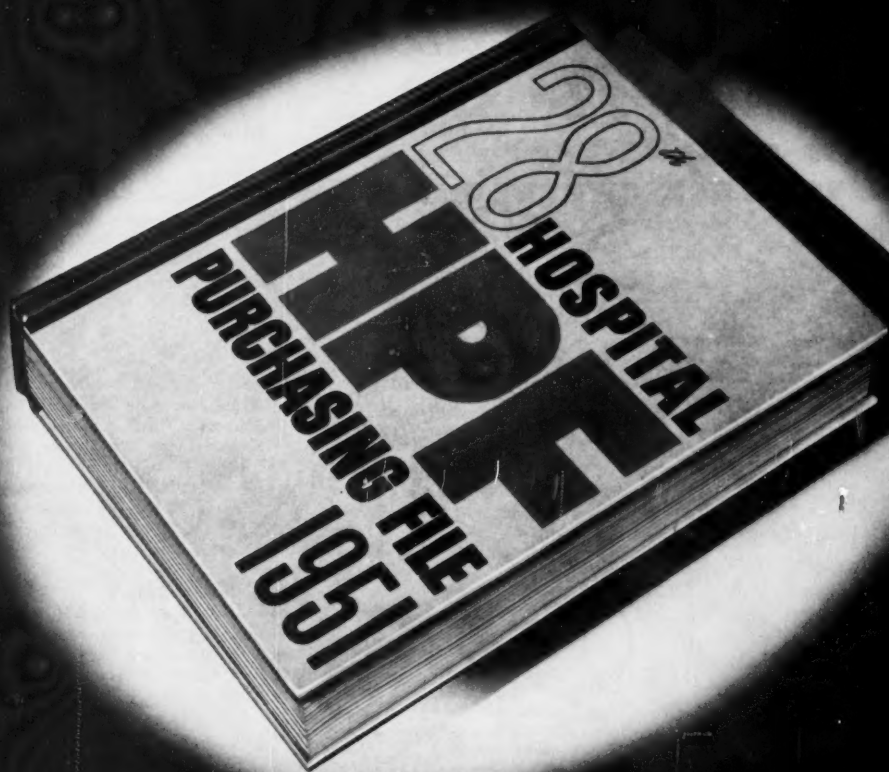
Here are the firms with products and services of specifically administrative interest which have filed information in Hospital Purchasing File.

## SECTION A

Acme Visible Records, Inc.  
Gray Mfg. Co.  
International Bronze Tablet Co., Inc.  
McGann & Sons Co., T. F.  
Matthews & Co., Jas. H., Memorial Bronze Division  
National Cash Register Co.  
Physicians' Record Co.  
Recordak Corporation, Subsidiary of Eastman Kodak Co.  
Remington Rand Inc.  
Spencer Studios, Inc.  
TelAutograph Corp.  
United States Bronze Sign Co., Inc.  
Wilcox Mfg. Co., W. W.

## SECTION H

American City Bureau  
American Hospital Supply Corp.  
American Surgical Trade Association, Inc.  
Beaver Associates, Inc.  
Garrett & Associates, Ross  
Haney & Associates, Inc., Charles A.  
Hogan, Winters and Co., Inc.  
Ketchum, Inc.  
Lawson Associates, Inc., B. H.  
Morris & Associates, J. Neil  
St. Paul Fire & Marine Insurance Co.  
Ward, Wells & Dreshman  
Wells Organizations, Inc.  
Will, Folsom and Smith, Inc.  
Woodward Medical Personnel Bureau



**PURCHASING FILES, INC.**

**919 N. MICHIGAN AVE., CHICAGO 11, ILL.**



## ABOUT PEOPLE

(Continued From Page 88)

ment of the board of directors of St. Luke's Episcopal-Presbyterian Hospital, St. Louis, a newly created post. Since 1944 Mr. Martin has been director of public relations at Washington University. In his new work one of his functions will be the coordination of effort in the current \$1,000,000 fund completion campaign for the enlargement and modernization of the present plant.

Bertha Byer is again superintendent of the Stafford District Hospital, Stafford, Kan., succeeding Gertrude Baseman, who had been acting superintendent on a temporary basis. Miss Baseman returned to her former duties as nurse in charge of surgery and also supervisor of the nursery at the hospital.

Viola Wolfe, R.N., has been named administrator of Wheaton Community Hospital at Wheaton, Minn., effective December 1. Mrs. Wolfe succeeded Marion Herder, R.N., who has been acting administrator.

George D. Roberts has accepted the

post of administrator at Rush County Memorial Hospital, La Crosse, Kan. Mr. Roberts, who succeeds Hardy J. Mays in his new post, is the former administrator of the Hodgeman County Hospital at Jetmore, Kan.

Dr. M. W. Conway has succeeded Dr. Bruce Hart as superintendent of Arizona State Hospital, Phoenix. Dr. Conway was assistant superintendent of Eastern State Hospital, Spokane, Wash., for 21 years and the hospital's superintendent from 1933 until 1944.

Dr. W. E. Denman has been appointed medical director of the new \$2,100,000 Tennessee State Tuberculosis Hospital, Chattanooga, Tenn. Dr. Denman was formerly engaged in the private practice of medicine at Memphis, Tenn., specializing in tuberculosis.

James E. Hatfield, John D. Alderman, and William M. Strange have been named assistant managers at Veterans Administration hospitals. Mr. Hatfield, chief of the special services division of the V.A. Hospital at Beckley, W.Va., will be the assistant manager at Altoona, Pa., succeeding Mr. Strange, who will be transferred to Omaha. Mr. Alderman, personnel officer of the V.A. Hospital at Oteen, N.C., will be the assistant manager at Lake City, Fla.

James McKelvey, formerly administrator of Chambersburg Hospital, Chambersburg, Pa., is now administrator of the Northwestern Hospital at Thief River Falls, Minn.

## Department Heads

Elizabeth W. Odell, R.N., director of the school of nursing of Evanston Hospital, Evanston, Ill., retired November 16 after 26 years of service. Miss Odell has been named director emeritus by the board of trustees. Graduated from Bishop's College, Lennoxville, Que., Miss Odell took her nurse's training at the General Hospital, Montreal, and also attended the school for graduate nurses at McGill University. During World War I she served four years in the Canadian army medical corps. From 1921 to 1923 she was assistant to the director of Evanston Hospital school of nursing, then went back to McGill for further study. On her return to Chicago she served as instructor at Grant Hospital school of nursing and the following year became director of the Evanston school.

Dr. Frode Jensen has been appointed associate dean of the New York University Post-Graduate Medical School, a unit of the New York University-Bellevue Medical Center. For the last year

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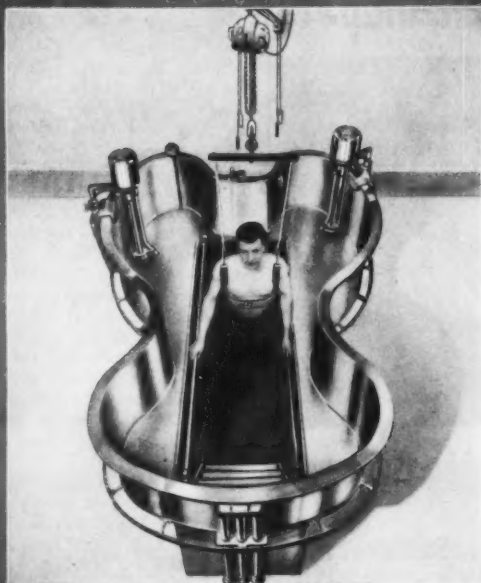


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For the postoperative care of  
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Maintenance Products Dept. MH12  
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Dr. Jensen has been assistant dean of the medical school and assistant director of the medical center's division of affiliated and regional hospitals. Dr. Jensen joined the medical school faculty after serving for three years as director of the office of graduate and postgraduate medical education and associate professor of medicine at the University of Colorado School of Medicine. A fellow of the American Medical Association and the New York Academy of Medicine, he also is a member of the American Trudeau Society and the American College of Physicians.

Mary Burke Thompson was appointed superintendent of nurses and principal of the school of nursing at Mount Auburn Hospital, Cambridge, Mass., November 1. Fanny Whitman was named head of volunteers at the hospital. In her new work Mrs. Whitman will work closely with the Mount Auburn Hospital auxiliary.

Bertha L. Alder has been appointed director of nursing of the Westchester School of Nursing, Grasslands Hospital, Valhalla, N.Y., to succeed Anna E. Ryle, who has occupied that post since Oct. 10, 1941. Miss Alder, a graduate of the Allentown General Hospital School of Nursing, Allentown, Pa., has been assistant director of nursing at Grasslands since June 1943.

Ellen Hesse is the newly appointed dietitian of Children's Memorial Hospital, Omaha, succeeding Mary Sweeney.

Sister Mary Cordelia, formerly stationed at St. John's Hospital, Leavenworth, Kan., has succeeded Sister Mary Faber as office supervisor at Our Lady of Perpetual Help Hospital, Falls City, Neb. Sister Mary Faber has been transferred to St. Joseph's Hospital, Deer Lodge, Mont.

Veda C. Swenson, director of nursing services at Menorah Hospital Medical Center, Kansas City, Mo., for the last five years, has become assistant director for patient care services. Mrs. Swenson will continue in the post of director of nursing services. Gordon E. Soncrant, formerly administrative assistant at Menorah, has been appointed to the new position of assistant director for administrative services.

Arthur F. Hornickel, since 1946 house-keeping director and laundry manager at Roosevelt Hospital, New York City, has been named administrative assistant at the Long Island College Hospital, Brooklyn, N.Y. He is first vice president of the National Association of Institutional Laundry Managers and past president of the New York City chapter.

# Miscellaneous

Warren R. Von Ehren, assistant superintendent of Bronson Methodist Hospital, Kalamazoo, Mich., for the last two years, joined the staff of the Council on Medical Education and Hospitals of the American Medical Association in Chicago, November 1. He will work primarily on the development of the new joint program of hospital accreditation. Mr. Von Ehren, who received his master's degree in hospital administration from Northwestern University in 1949, is a nominee of the American College of Hospital Administrators.

Lewis G. Hersey, executive director of Blue Cross in Utah for the last two years, has been named executive director of both Blue Cross and Blue Shield, succeeding Allen H. Tibbals, who held the post since 1947. Mr. Hersey assumed his duties with Blue Cross in 1949. He came to Utah following a period of service with Michigan's Blue Cross and Blue Shield plans.

Dr. Joseph W. Mountin has been appointed chief of the Bureau of State Services, Public Health Service, succeeding Dr. C. L. Williams. Dr. Mountin, an associate chief of the Bureau of State Services since 1947, is known throughout the field of public health as the "father" of many service programs. A diplomate of the American Board of Preventive Medicine and Public Health, he also is a fellow of the American Medical Association and the American Public Health Association. Dr. Williams is a fellow of the American Public Health Association, a diplomate of the American Board of Preventive Medicine, and a member of the American Medical Association, the American Society of Tropical Medicine, the National Malaria Society, the United States-Mexico Border Public Health Association, the Association of Military Surgeons, and the National Pest Control Association.

Stanley W. Martin, formerly assistant superintendent of the Toronto East General & Orthopaedic Hospital, is now associate executive secretary-treasurer and controller of the Ontario Hospital Association in Canada. President of the Toronto Hospital Council, he also is chairman of the accounting section of the Ontario Hospital Association, and has served as a member of the committee on accounting and statistics of the Canadian Hospital Council. He is a personal member of the American Hospital Association and a nominee of the American College of Hospital Administrators.

Yellena Severs has been appointed to the headquarters staff of the American



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Johnson's powerful new Wet-Dry Vac makes light work of big cleaning jobs. Cleans thoroughly, quickly, easily. Versatile, sturdy, quiet, easy to move. Complete with standard tools for most jobs... special accessories for other work. Full flexible hose—steel cleaning wand—large floor tool—upholstery tool—super-suction rubber squeegee—35' pull-out-proof rubber cord set—U.L.-approved. Built-in static and noise eliminator.

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- Shop floor pick-up
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## what's under the frosting?

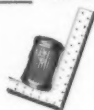
Fancy frosting can only conceal an inferior cake temporarily and it's the same with an inferior Can. The shiny finish fades and the true value shows through. Not so with WITT CANS . . . top to bottom, from the heavy gauge steel to after-fabrication galvanizing . . . they contain the best of materials and workmanship. WITT CANS' longer life makes them well worth waiting for . . . in these days of shortages.

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College of Hospital Administrators as executive assistant. Miss Seever, a former administrator of Bath Memorial Hospital, Bath, Me., was hospital specialist in the hospital section of the War Production Board at Washington, D.C., during World War II. Since 1947 she has been an associate director of Will, Folsom and Smith, Inc., fund-raising specialists of New York.

Harry Becker is the new associate director of the commission on financing of hospital care of the American Hospital Association. The former director of the social security department of the U.A.W.-C.I.O., he also served as labor representative on the boards of trustees of Michigan Hospital Service and Michigan Medical Service (Michigan Blue Cross and Blue Shield plans). Earlier in his career Mr. Becker directed the administrative methods unit of the U.S. Children's Bureau, Federal Security Agency.

Dr. Jack R. Ewalt has been named Commissioner of Mental Health of Massachusetts. He fills the position left vacant by the resignation of Dr. Clifton T. Perkins more than a year ago. Dr. Ewalt, who has been dean of the post-graduate school of medicine at the University of Texas since 1950, began his career at the army's Fitzsimons Hospital in Denver as contract physician and neuropsychiatrist. From 1938 to 1941 he was assistant professor of psychiatry at the University of Colorado and from 1941 to 1944 he was first associate and then full professor of neuropsychiatry in the medical branch of the University of Texas. From 1944 to 1950 he held the joint post of director of the department of electroencephalography, director of the Psychopathic Hospital of the University of Texas, and administrator for the medical branch hospitals of the university.

## Deaths

John M. Storm, editor and business manager of *Hospitals*, journal of the American Hospital Association, and *Trustee* magazine, died November 4 in Chicago. Mr. Storm began his career on newspapers in Iowa and was on the staff of the *Indianapolis Star* before becoming associate editor of the *Cleveland News*. He left this post in 1943 to become editor of the A.H.A. journal, and four years later helped establish *Trustee*.



John M. Storm

## COMING MEETINGS

FLORIDA HOSPITAL ASSOCIATION, Wyoming Hotel, Orlando, Dec. 3, 4.

MISSOURI HOSPITAL ASSOCIATION, St. Louis, December 6.

1952  
AMERICAN COLLEGE OF CLINIC ADMINISTRATORS, Stevens Hotel, Chicago, Jan. 13-15.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Fellows' Seminar, University of Michigan, Ann Arbor, Dec. 5-8.

AMERICAN HOSPITAL ASSOCIATION, Philadelphia, Sept. 15-18.

AMERICAN HOSPITAL ASSOCIATION MID-YEAR CONFERENCE, Drake Hotel, Chicago, Feb. 8, 9.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Hotel Statler, Cleveland, Feb. 21, 22.

ARIZONA HOSPITAL ASSOCIATION, Phoenix, Feb. 14-16.

ARKANSAS HOSPITAL ASSOCIATION, Arlington Hotel, Hot Springs, May 5-6.

ASSOCIATION OF WESTERN HOSPITALS, San Francisco, May 12-15.

BLUE CROSS-BLUE SHIELD ANNUAL CONFERENCE, Fairmont and Mark Hopkins hotels, San Francisco, March 31-April 3.

CATHOLIC HOSPITAL ASSOCIATION, Cleveland, May 26-29.

CATHOLIC SCHOOLS OF NURSING, Public Auditorium, Cleveland, May 24, 25.

EPISCOPAL HOSPITAL ASSEMBLY, Hotel Statler, Cleveland, Feb. 21.

GEORGIA HOSPITAL ASSOCIATION, Atlanta Biltmore Hotel, Atlanta, Feb. 7, 8.

KENTUCKY HOSPITAL ASSOCIATION, Seelbach Hotel, Louisville, March 25-27.

MASSACHUSETTS HOSPITAL ASSOCIATION, Copley-Plaza Hotel, Boston, Jan. 15.

MICHIGAN HOSPITAL ASSOCIATION, Statler Hotel, Detroit, Nov. 9-11.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 21-23.

MID-WEST HOSPITAL ASSOCIATION, President Hotel and Municipal Auditorium, Kansas City, Mo., April 23-25.

MINNESOTA STATE MEDICAL ASSOCIATION, Minneapolis Auditorium, Minneapolis, May 28-29.

NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Statler Hotel, Cleveland, Feb. 20-21.

NATIONAL EXECUTIVE HOUSEKEEPERS ASSOCIATION, Rice Hotel, Houston, Tex., May 21-24.

NEW ENGLAND HOSPITAL ASSEMBLY, Statler Hotel, Boston, March 24-26.

NEW JERSEY HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, May 21-23.

OHIO HOSPITAL ASSOCIATION, Cleveland Hotel, Cleveland, March 31-April 3.

RHODE ISLAND HOSPITAL ASSOCIATION, Miriam Hospital, Providence, Dec. 13.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta, Ga., April 16-18.

TEXAS HOSPITAL ASSOCIATION, Shamrock Hotel, Houston, May 20-22.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 28-30.

UPPER MID-WEST HOSPITAL CONFERENCE, Lowry and St. Paul Hotels, St. Paul, May 14-16.

WISCONSIN HOSPITAL ASSOCIATION, Schroeder Hotel, Milwaukee, Feb. 14.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 24-25.

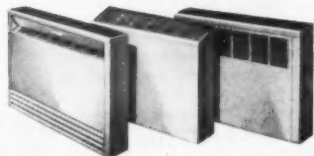




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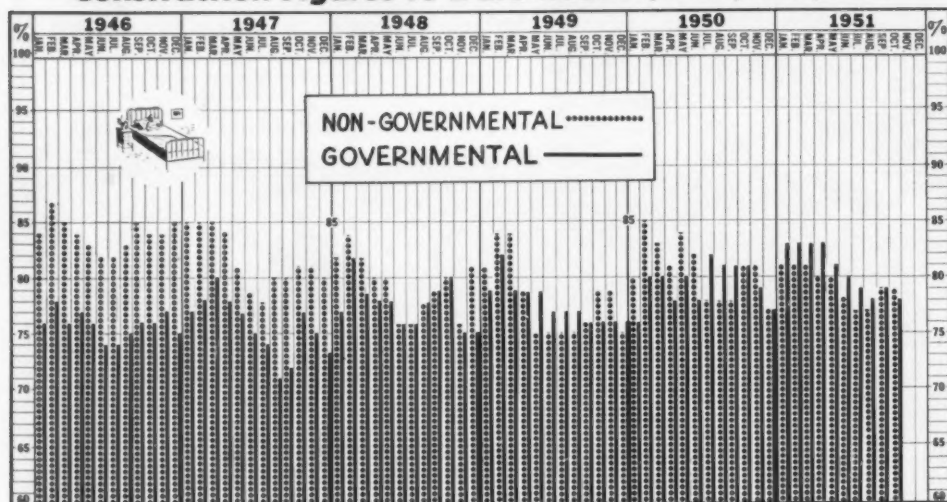


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## Construction Figures to Date Reach \$749,663,729



The latest figures received from non-governmental hospitals indicate that occupancy has climbed to 79.4 per cent of capacity for the month of October, and governmental hospital figures show a slight decline from last month with

occupancy reported at 77.7 per cent.

For the period ending November 5, hospital construction amounted to \$37,417,984, making the total for the year thus far \$749,663,729—slightly below the figure reported for October 1950.

Projects reported for the latest period included 19 hospitals costing \$14,591,940; 39 additions totaling \$32,027,338, and four nursing homes. The cost of one nursing home addition was reported at \$90,000.

### Pamphlets stay neater . . . last longer in **GAYLORD BINDERS**

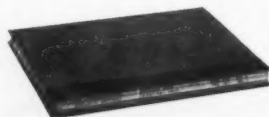
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Visionaire canopies are made of a plastic having inherent characteristics that make it especially suited to this use. It is transparent as fine glass; odorless; has a high tensile strength; is resistant to the effects of high oxygen concentration. Sixty inch, full length skirts stay "tucked in"; electronically welded seams eliminate leaks. Not all plastics have the physical properties to qualify for this purpose.

The usual seasonal increase of iceless oxygen tents during the coming months and the maximum availability of this special plastic material may tax and limit the quantity but not the quality of Visionaire canopies we are able to produce.

We recommend that an inventory be made of your oxygen tents and canopy stock and your requirements for the next 90 days be anticipated. In this way our production can be allocated to provide supplies to the greatest number of hospitals and avoid "depleted stock emergencies."

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## POSITIONS WANTED

**ADMINISTRATOR**—100-bed hospital or larger; experience includes administrator of 100-bed hospital, eight years as assistant administrator of 250-bed hospital, duties also included purchasing, personnel and public relations; 6 years' public accounting and auditing experience; immediately available. MW 54, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**DIRECTORSHIP or ASSISTANCY**—New York; M.A. Degree; strong background in organization, accounting and personnel; public relations experience; age, 37. MW 60, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**LIBRARIAN**—Medical record; registered; experience, 15 years in all phases; wants change; prefer Missouri, Illinois, Iowa; now employed. MW 61, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**SALES POSITION**—With reliable manufacturer of hospital equipment or surgical supplies, now calling on hospitals in the Dakotas, Iowa and Minnesota; good selling record. MW 62, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.



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## WOODWARD—Continued

**ADMINISTRATOR**—Lay; experience includes 4 years, assistant administrator, and 8 years, director important 300-bed university hospital; active in national hospital affairs; member, House of Delegates, American Hospital Association; and member, ACHA, exceptionally well qualified; seeks hospitals 250 beds up; prefers warm climate; immediately available.

**ANESTHESIOLOGIST**—Certified; early 30's; several years, chief, department anesthesiology, United States Army Hospital; 1 year, anesthesiologist, university hospital; past 3 years, associate, private practice of anesthesiology; immediately available.

**ANESTHESIOLOGIST**—38; passed Part I; 2½ years, medical officer; excellent residencies and postgraduate work; 5 years, private practice, anesthesiology; presently, chief of anesthesiology, large eastern hospital; will consider part-time teaching, immediately available.

**ANESTHETIST**—34; registered AANA; graduate of approved hospital course; 2 years' experience; asking \$4500; available soon.

**BACTERIOLOGIST**—28; married; Masters Degree; 2 years' experience; salary \$3600; immediately available.

**DIETITIAN**—48; registered; Masters Degree; 14 years' experience responsible positions; \$4000; available soon.

**DIRECTOR OF NURSES**—53; single; graduate, Columbia University; 15 years' experience as instructor and supervisor; 3 years, assistant director of nurses, large hospital; \$3600; immediately available.

**HOUSEKEEPER**—51; single; 5 years' experience; \$2400 and maintenance.

**PATHOLOGIST**—Certified in both branches; graduated Hahnemann Medical College; several years' private practice of pathology; past several years, state pathologist and also pathologist several hospitals, capacities over 250 beds; seeks directorship, laboratories in hospitals 200 beds up; any locality; early 40's; immediately available.

**PATHOLOGIST**—35; certified in both branches; excellent residencies, university hospitals; past 2 years, pathologist and director of laboratories, important eastern university hospital; draft exempt.

**PHARMACIST**—Female; 42; registered; single; graduate, University of California; 20 years' experience; available 30 days.

**RADIOLOGIST**—Diplomate in both branches; also certified in radiology, Royal College of Physicians and Surgeons, Canada; past 6 years, director, department of radiology, 700-bed university hospital; seeks exceptional opportunity; any locality; highly recommended.

**RADIOLOGIST**—34; excellent training and experience; certified in diagnostic and therapeutic radiology; World War II veteran; prefers southwest or west; immediately available.

## WOODWARD—Continued

**RECORD LIBRARIAN**—Single; 50; 20 years' experience; registered; desires responsible appointment; available soon.

**TECHNICIANS**—(a) Head technician; 31; single; B.S. in Medical Technology; 5 years' experience; salary \$4200; available soon. (b) Medical technologist; 25; single; college graduate; registered ASCP; 3 years' experience; \$3600; available 60 days.

**X-RAY AND LABORATORY TECHNICIANS**—(a) 41; widow; no children; member, American Registry of X-ray Technicians; 12 years' experience; \$3600. (b) Male; 26; single; college graduate; member, ASCP; 5 years' experience; \$4200; immediately available.

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**COMPTROLLER**—Or business manager; age, 43 years; graduate Temple University; accounting major; 2 years assistant comptroller; past 2 years chief accountant, 300-bed Pennsylvania hospital.

**ADMINISTRATOR**—College graduate; 8 years business administration; 75-bed eastern hospital; 3 years, 150-bed Maryland hospital.

**ADMINISTRATOR**—A.B. Degree, University of Wisconsin; 15 years administrator, 125-bed hospital, Illinois; familiar with building construction; at present, director 110-bed mid-western hospital.

**ASSISTANT DIRECTOR**—12 years' experience in business administration; past 4 years public relations director, 200-bed hospitals, south and mid-west; fund campaign direction experience.

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**ADMINISTRATOR**—Lay; Degree in Business Administration; six years, assistant superintendent, large teaching hospital; eight years, director, 275-bed hospital; Fellow, American College of Hospital Administrators.



# classified advertising

## POSITIONS WANTED

### MEDICAL BUREAU—Continued

**ADMINISTRATOR**—B.S., Business Administration; M.S., Hospital Administration; four years' accounting experience before specializing; administrative internship, teaching hospital; three years' administrative assistant, 400-bed hospital; wishes assistant directorship, large hospital or directorship small hospital.

**ANESTHESIOLOGIST**—Diplomate; five years, director, anesthesiology, 300-bed hospital; seven years, director, departments two hospitals, private practice.

**ADMINISTRATOR**—Registered nurse; member American College of Hospital Administrators; since 1946, director, 100-bed general hospital; particularly well qualified in public relations.

**MALE NURSE**—Graduate, teaching hospital; B.S., Nursing Education; six years, supervising experience, 500-bed teaching hospital; 5 years, assistant night superintendent, Veterans' Administration hospital.

**PATHOLOGIST**—FACP; Diplomate, Clinical Pathology, Anatomical Anatomy; eight years, director pathology, large, general hospital and associate pathologist, university school of medicine.

### MEDICAL BUREAU—Continued

**MEDICAL DIRECTOR**—Tuberculosis specialist; eleven years, director, county sanatorium; broad knowledge of tuberculosis medicine.

**RADIOLOGIST**—Diplomate, Therapeutic and Diagnostic; five years, radiologist, group clinic; teaching and research, cancer; prefers directorship, hospital department.

**PUBLIC RELATIONS DIRECTOR**—Ph.B., middle western university; fifteen years' experience in the hospital field as director of public relations.

## POSITIONS OPEN

**ADMINISTRATOR**—Male or female, for 35-bed hospital; northern New Jersey, 30 miles from New York City; give experience, references, and salary expected. MO 59, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**ANESTHETIST**—Nurse; for 162-bed hospital expanding to 231; convenient to Pittsburgh, 1-hour; 4 anesthetists employed; salary \$800 monthly with periodic raises and maintenance plus sick leave, holiday time, 1 month vacation; excellent working conditions. Apply, Charlevoix-Monessen Hospital, Charlevoix, Pennsylvania.

**ANESTHETIST**—Nurse; fully approved general hospital of 300 beds; salary open; Apply, Doctor Ralph E. Schopfer, Anesthesiologist, The Williamsport Hospital, Williamsport, Pennsylvania.

**ANESTHETIST**—Nurse; 60-bed general hospital; new building, modern equipment; western Wisconsin, college town; vacation, sick leave, retirement plan. Apply to H. C. Gantner, Manager, Memorial Hospital, Menomonie, Wisconsin.

**ANESTHETIST**—Well trained and experienced; general hospital of 141 adult beds for white women only; salary open; maintenance if desired. Apply, Director, The Hospital for the Women of Maryland, Baltimore 17, Maryland.

**ANESTHETIST**—Nurse; 187-bed general hospital; 15 miles north of Pittsburgh, Pennsylvania; salary, \$275-\$300 plus meals and laundry; 50-hour week policy; 28 days vacation; 10 days sick leave; 5 holidays or equivalent. Apply, Superintendent, Sewickley Valley Hospital, Sewickley, Pennsylvania.

**ANESTHETIST**—Nurse; night duty, 80% of anesthesia for obstetrical patients; department headed by medical anesthesiologist; 250-bed hospital; city 50,000; 75 miles from New York City; salary open. Apply, Administrator, Vassar Brothers Hospital, Poughkeepsie, New York.

(Continued on page 182)



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# classified advertising

## POSITIONS OPEN

**ANESTHETIST**—Nurse: for surgical and obstetrical; starting salary \$350 a month. Methodist Hospital, Sixth Street and Seventh Avenue, Brooklyn, New York. South 8-6000, Extension 142.

**ANESTHETIST**—Nurse: for New Rochelle Hospital, a general, fully approved hospital seventeen miles outside New York City in Westchester County; salary open. Please direct replies to Superintendent, New Rochelle Hospital, New Rochelle, New York.

**ANESTHETIST**—Nurse: for 100-bed cancer hospital; active major surgical service; full time surgeon; congenial working conditions; excellent equipment; salary open. Apply, Medical Director, The Ellis Fischel State Cancer Hospital, Columbia, Missouri.

**ANESTHETISTS**—Nurse: two urgently needed; modern, well equipped, 100-bed hospital, employing only graduate staff; attractive location within forty minutes of San Francisco; 5-day week; excellent salary; maintenance available. Administrator, Alameda Hospital, Alameda, California.

**ANESTHETISTS**—Nurse: four; salary \$350 per month, plus full maintenance. Write, Director, Hamot Hospital, Erie, Pennsylvania.

**ANESTHETISTS**—Nurse: 200-bed fully approved hospital; salary \$350-\$400 monthly, maintenance optional; vacation, sick leave, insurance. Apply, Director, Franklin Square Hospital, Baltimore 23, Maryland.

**CONSULTANT**—Hospital dietary; for state health department; ADA member; minimum of 4 years' experience as administrative dietitian; salary range, \$3780 to \$4560. Write Thomas Wulch, Personnel Officer, Ohio Department of Health, Columbus 15, Ohio.

**COOK**—200-bed hospital in Michigan, located in city of 200,000; pleasant surroundings; 44-hour week; salary commensurate with experience and qualifications. MO 41, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**DIETITIAN**—Registered: for 100-bed approved general hospital with school of nursing; salary open; good working conditions and personnel practices. Apply, Kenneth L. Williams, Administrator, Pulaski Hospital, Pulaski, Virginia.

**DIETITIAN**—200-bed hospital in Michigan, located in city of 200,000; pleasant surroundings; salary commensurate with experience and qualifications. MO 39, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**DIETITIAN**—Therapeutic: 300-bed approved general hospital, in central Pennsylvania. Apply, D. W. Hartman, Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

**DIETITIAN**—The Baltimore City Hospitals, Baltimore, Maryland, invites inquiries about a permanent position with many attractive possibilities which is now available; your inquiry will bring a prompt reply concerning starting salary, conditions of work, personnel policies and other interesting phases of employment.

**DIETITIAN**—Registered: wanted for a fully approved 150-bed hospital; good salary and pleasant surroundings. Apply Mother Marie, Maryview Hospital, Portsmouth, Virginia.

**DIETITIAN**—Registered: wanted for 56-bed hospital; all new equipment; town of 5000 population. MO 51, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**DIETITIAN**—Therapeutic and assistant; immediate opening; 200-bed approved hospital in western suburb of Chicago. Apply, Dietitian, Memorial Hospital, Elmhurst, Illinois.

**DIETITIAN**—Qualified and experienced for 162-bed general hospital with school of nursing; state age, qualifications, religion and salary expected. Apply, Superintendent of Nurses, General Hospital, Glace Bay, Nova Scotia.

**DIETITIAN**—Chief: ADA, to head dietary department in one of midwest's foremost psychiatric hospitals; training program here attracts national attention; this position will appeal to experienced person who has exceptional ability. Contact Personnel Officer, Topeka State Hospital, Topeka, Kansas.

(Continued on page 184)

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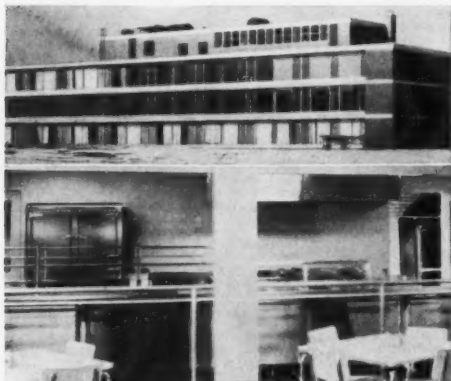
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Top Photo: Exterior view of Schoitz Memorial Hospital.

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Herrick units were supplied by Albert Pick Co., Inc., Chicago. Architects were Skidmore, Owings & Merrill, Chicago and New York.

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Curved head of malleable iron. Sanded and waxed hardwood handle. Simple adjustment. Choice of handle lengths on all WHITE mop sticks.

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# classified advertising

## POSITIONS OPEN

**DIETITIAN**—For 100-bed hospital; salary depends on experience and qualifications. For particulars apply, Superintendent, Soldiers' Memorial Hospital, Campbellton, New Brunswick.

**DIETITIAN**—Administrative head of department in 400-bed hospital, on west coast, with approved school of nursing and dietetic intern program; salary open; state education and experience. Address communications to Administrator of Good Samaritan Hospital, Portland, Oregon.

**DIETITIAN**—Registered; administrative; with previous supervisory experience, for modern 200-bed hospital; dietary staff of 46 employees; modern kitchen equipment; salary, beginning January, 1952, \$351 per month; 6 months' increase to \$364, regular anniversary increments for 3 years; 7 paid holidays, 2 weeks' vacation and 12 days' sick leave per year; cafeteria meal service; laundry furnished. Apply, Director, Pontiac General Hospital, Pontiac, Michigan.

**DIRECTOR OF NURSES**—For new 72-bed general hospital; no nursing school; salary \$3300 per year, meals furnished; located in the heart of the beautiful, irrigated Yellowstone valley of eastern Montana. Apply, Administrator, Community Memorial Hospital, Sidney, Montana.

**DIRECTOR OF NURSING**—Qualified for nurses' training school, in coordinated school of nursing; 105-bed hospital; salary \$325 per month or \$310 per month with room, meals and laundry. MO 43, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**DIRECTOR OF NURSING**—In a 300-bed general hospital with a school of nursing of 200 students. Apply Administrator, Arkansas Baptist Hospital, Little Rock, Arkansas.

**DIRECTOR OF NURSING**—300-bed general hospital with a school of nursing with college affiliation. Apply, Superintendent, Mississippi Baptist Hospital, Jackson, Mississippi.

**HOUSEKEEPER**—200-bed hospital in Michigan, located in city of 200,000; pleasant surroundings; 44-hour week; salary commensurate with experience and qualifications. MO 40, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**INSTRUCTOR**—Surgical clinical; 600-bed general hospital; 200 students; operating and recovery room not included in this assignment. For details contact, Director of Nursing Service, Jackson Memorial Hospital, Miami 36, Florida.

**INSTRUCTOR**—Clinical; for medical and surgical nursing and obstetric nursing for 187-bed hospital; B.S. Degree required; one with experience preferred; salary open; 40-hour

week. Apply, Director of Nurses, St. Margaret's Hospital, Montgomery, Alabama.

**INSTRUCTOR**—Clinical, medical and surgical for 350-bed hospital with school of nursing; 44-hour week; 30 days' vacation; 12 days' sick allowance; near New York City; salary open; position available now. Apply, Director of Nursing, Perth Amboy General Hospital, Perth Amboy, New Jersey.

**INSTRUCTOR**—Science; for 100-bed general hospital school of nursing; good working and living conditions; salary open, depending upon training and experience. Apply, Director of Nursing Science, Pulaski Hospital, Pulaski, Virginia.

**INSTRUCTORS**—Clinical; for operating room and obstetric nursing; fully approved 240-bed hospital with expansion to add 200 beds; large student body; fully approved school of nursing; university affiliation; 40-hour week; inservice programs; salary open. MO 46, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**LIBRARIAN**—Medical record; 300-bed general hospital in central Pennsylvania; salary open. Apply, The Williamsport Hospital, Williamsport, Pennsylvania.

**MISCELLANEOUS**—Well qualified Director of nurses for 250-bed North Carolina Hospital; also Dietitian, ADA, for same institution. Memorial Mission Hospital, Asheville, North Carolina.

(Continued on page 186)

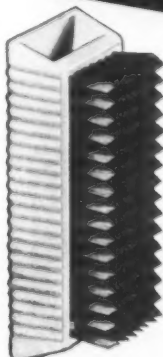
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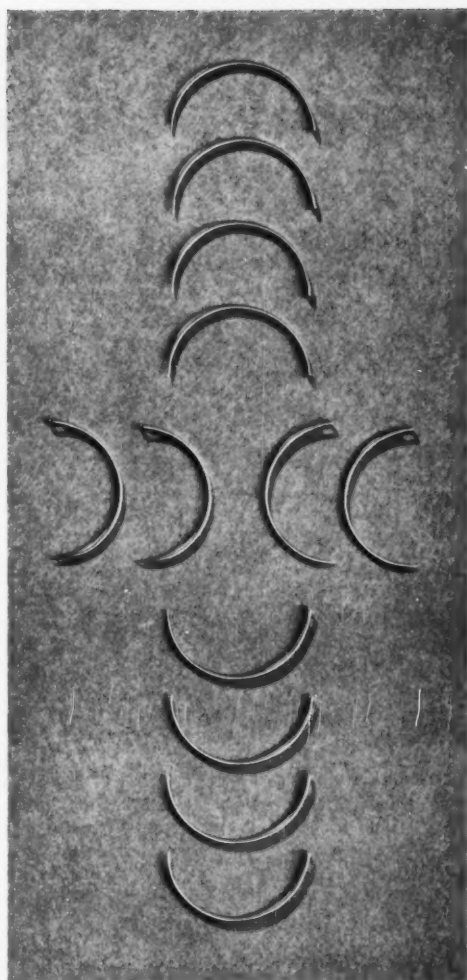
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# classified advertising

## POSITIONS OPEN

**MISCELLANEOUS**—Administrative supervisors and Clinical instructors for operating room and obstetric department; fully approved 240-bed hospital with expansion to add 200 beds; large student body; fully approved school of nursing; university affiliation; 40-hour week; in-service programs; salary open, MO 54, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**MISCELLANEOUS**—Nurse anesthetist; also, two Registered nurses for 35-bed general hospital; Texas gulf coast; salaries open, Write, Bay-View General Hospital, L. A. Wilcox, M.D., Palacios, Texas.

**MISCELLANEOUS**—Nurse anesthetist and Physical therapist wanted immediately at Kadlec Hospital, Richland, Washington; operated by General Electric Company for the Atomic Energy Commission; Kadlec Hospital is a completely modern 103-bed general hospital located in the Pacific Northwest; it is ACS approved and offers very attractive salaries; operated by General Electric, it also has liberal employee benefits including sick leave, paid vacations, pensions, low cost life and health insurance and stock bonus plans. For details, wire collect name and address, Administrator Kadlec Hospital, Richland, Washington.

**MISCELLANEOUS**—Instructors for affiliate schools of psychiatric nursing; psychiatric nursing and B.S. in Nursing Education required, M.S. preferred; salary \$3300-\$5000; Supervising nurses—\$3000-\$4800; Head nurses—\$2700-\$4300; Staff nurses—\$2300-\$3900. Write, Supervisor Personnel Service, Department of Public Welfare, State Armory, Springfield, Illinois.

**MISCELLANEOUS**—Pediatric supervisor and Clinical instructor; for 26-bed pediatric service, in 250-bed hospital; teaching responsibilities, pediatric classes and ward conferences; beginning salary \$260 per month, maintenance if desired. For further information write, Director of Nurses, Vassar Brothers Hospital, Poughkeepsie, New York.

**MISCELLANEOUS**—Supervising nurse for brand new tuberculosis sanatorium in beautiful San Mateo County, California; salary range \$332-\$415; excellent working conditions; positions also available for Head nurse, \$297-\$71 and Staff nurses, \$266-\$332 and Hospital attendants, \$213-\$266. San Mateo County Civil Service Commission, Courthouse, Redwood City, California.

**MISCELLANEOUS**—Experienced Surgical nurse; \$275 month, complete maintenance, two weeks' paid vacation, ten days' sick leave, six holidays; call every other night; Registered nurses for general floor duty; \$200 month, with complete maintenance. Robstown Hospital, Inc., Robstown, Texas.

(Continued on page 188)

**NURSE** Head; for 17-bed medical and surgical mission hospital, located in eastern Kentucky; salary and full maintenance. Write, Jane Cook Hospital, Frenchburg, Kentucky.

**NURSE**—Instrument; \$325 per month plus full maintenance; 70-bed hospital; western Pennsylvania college town, MO 55, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**NURSE**—Registered; for general duty; meals while on duty and laundry of uniforms. Apply Business Manager, Floyd County Co-operative Hospital, Lockney, Texas.

**NURSE**—Registered; with post-graduate work in pediatrics; 125-bed approved hospital. Apply, Sacred Heart Hospital, Havre, Montana.

**NURSES**—General duty and operating room; 5 days, 40 hours; paid vacation, Social Security, death and accident policy for permanent employees; live in or out; attractive nurses' residence; in heart of New York City. Write, Director of Nurses, Medical Arts Center Hospital, 57 West 57th Street, New York City.

**NURSES**—General duty; on all services including operating room; general hospital, fully approved; 44-hour week, day duty; 40-hour week 3 to 11; 11 to 7 shifts with differential of \$10 a month; starting salary \$200 per month; 7 holidays, vacation, sick time allowance. Apply, Director of Nurses, Franklin Square Hospital, Baltimore 23, Maryland.

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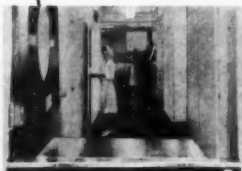
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**NURSES**—General duty; come to Miami, the south's vacation land: 600-bed, rapidly expanding general hospital; beginning salary \$219; excellent opportunity for advancement; 3 weeks vacation and 7 holidays annually; semi-private rooms for three months at nominal fee. Apply Director of Nursing Services, Jackson Memorial Hospital, Miami 36, Florida.

**NURSES**—General duty; for 360-bed general hospital; starting salary \$175 per month with maintenance; \$200 per month with partial maintenance; rotating shifts; two weeks' vacation; 30 days' sick leave; 6 holidays yearly with pay; 44-hour week; college courses available through night classes at local university. Apply Director of Nursing, Greenville General Hospital, Greenville, South Carolina.

**NURSES**—General duty; eligible for registration in Michigan; modern 200-bed hospital; salary, beginning January, 1952, \$253.50 per month for 40-hour week; six months' increase to \$260, and anniversary increases of \$6.50 per month through third anniversary; \$10 extra for 3-11 and 11-7 duty; 7 paid holidays, 2 weeks' vacation and 12 days' sick leave per year; cafeteria meal service; laundry furnished. Apply, Superintendent of Nurses, Pontiac General Hospital, Pontiac, Michigan.

**NURSES**—General duty; two; wanted immediately for Skidegate Inlet General Hospital of the United Church of Canada; Queen Charlotte Islands; \$200 per month, less \$30 maintenance; \$10 annual increment; one month vacation with pay after one year; transportation allowance to \$65 paid after six months, return fare after one year. Apply, Secretary, Queen Charlotte City, British Columbia.

**NURSES**—General duty; for 300-bed hospital in nation's capital; opportunity for furthering education as located near several universities; pleasant working conditions; coffee hour in AM and PM; paid vacation, 6 holidays, sick leave, hospitalization, Social Security, meals and laundry cash basis; opportunities for promotion; starting salary of \$215 per month with \$5 increase after 6 months, 12 months, 24 months, and 36 months service; pay for overtime; additional pay for evening and night duty and for operating room, delivery room, blood bank and rectifying room services. Apply, Director of Nursing, Garfield Memorial Hospital, Washington, District of Columbia.

**NURSES**—General duty; for 50-bed hospital in city of 10,000; retirement, vacation, paid holidays and sick leave. Write, Owatonna City Hospital, Owatonna, Minnesota.

**NURSES**—Graduate; for 40 bed private hospital in gulf coast area of Texas; maintenance available, if desired; rotating shifts; salary open. Apply, Administrator, Caney Valley Hospital, Wharton, Texas.

**NURSES**—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary \$200 to \$210 week; full maintenance available for \$10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

**NURSES**—Head; assistant; for surgical-medical, nursery and postpartum wards; salary \$270 to \$290 in 18 months; paid vacation, sick leave, holiday time. Apply, Director of Nurses, Woman's Hospital, 432 East Hancock Avenue, Detroit 1, Michigan.

**NURSES**—Operating room and obstetrical; California hospital on San Francisco Bay; forty minutes from that city; 5-day week; salary \$250 per month if applicant has advanced preparation or experience; \$10 additional for evening and night duty; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

**NURSES**—Pediatric; for 200-bed teaching institution, located in residential section of city; good personnel policies; minimum salary is \$200 per month; one meal a day while on duty; 4½ hour week; 7 holidays; housing may be secured in nurses' residence. Apply, Director of Nursing, Children's Hospital of Buffalo, 219 Bryant Street, Buffalo, New York.

(Continued on page 190)

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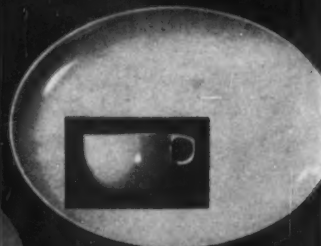
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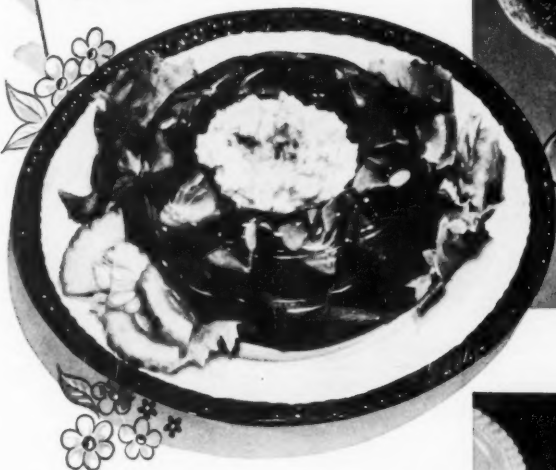


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# classified advertising

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**NURSES**—Practical; graduates of schools approved by Michigan Board of Registration for nurses and trained attendants; modern 200-bed hospital; salary, beginning January, 1952, \$214.50 per month for 40-hour week; 6 months' increase to \$221 per month, and anniversary increases of \$6.50 per month through third anniversary; \$10 extra for 3-11 and 11-7 duty; 7 paid holidays, 2 weeks' vacation and 12 days' sick leave per year; cafeteria meal service; laundry furnished. Apply, Superintendent of Nurses, Pontiac General Hospital, Pontiac, Michigan.

**NURSES**—Psychiatric; men and women; for general duty positions open in a psychiatric wing of a 750-bed hospital. Write, Director of Nursing, Buffalo General Hospital, 100 High Street, Buffalo, New York.

**NURSES**—Registered; graduate; for general duty; gives opportunities for experience in all types of medical and surgical services and specialties, including outpatient department; salary \$225 per month for 44-hour week, with increases at six months, one year and two years; \$20 differential for evening and night duty; \$30 per month additional for psychiatry; social security provided. Apply Superintendent of Nurses, Barnes Hospital, 600 South Kingshighway, St. Louis, Missouri.

**NURSES**—Registered; graduate; for general duty in eye, ear, nose and throat services and psychiatry; salary \$225 per month for 44-hour week with increases in six months, one year and two years; \$20 differential for evening and night duty; \$30 per month additional for psychiatric nursing; social security provided. Apply Superintendent of Nurses, McMillan Hospital, 440 South Kingshighway, St. Louis, Missouri.

**NURSES**—Registered; Hermann Hospital in the Texas Medical Center offers you unlimited opportunities; positions with pleasant working conditions are available now. Write, Director of Nurses, Hermann Hospital, Houston, Texas.

**NURSES**—Staff and operating room; 5-days, 40-hours, 8 holidays and vacation with pay; initial salary \$220 plus laundry; increases at 6 and 18 months; additional pay for evening and night assignments and for operating room calls. Apply, Director of Nursing, St. Luke's Hospital, New York 25, New York.

**NURSES**—Staff; for large tuberculosis hospital; 44-hour week, all holidays, 3 weeks' paid vacation; transportation allowance after one year's service; inservice educational program; group insurance; social security and retirement benefits; minimum salary head nurse, \$240; staff nurse, \$223; maintenance, \$45 deductible. For further information write airmail, Director of Nursing, Lenhi Hospital, Honolulu 16, Hawaii.

**NURSES**—Staff; registered or eligible for registration; 40-hour week; salary \$200 per month with meals, laundry, Social Security, vacation, sick leave, holidays; rooms available in nurses' home if desired. Apply, Superintendent of Nurses, New York Eye and Ear Infirmary, 218 Second Avenue, New York 3, New York.

**NURSES**—General staff; must rotate or be willing to work permanent afternoon or night duty; 40-hour week, liberal personnel policies; \$20 month afternoon or night bonus. Write Director of Nurses, Jewish Hospital, Cincinnati 29, Ohio.

**NURSES**—General staff; 150-bed hospital; 44-hour week; \$200 per month to start; 2 meals per day; retirement; hospitalization; vacation, sick leave. Apply, Director of Nurses, Burnham City Hospital, Champaign, Illinois.

**NURSES**—Staff; for a general hospital on medical, surgical and obstetric services; also vacancies on operating room staff; good personnel policies. Apply to Director of Nursing, Buffalo General Hospital, 100 High Street, Buffalo, New York.

**NURSES**—Staff; part or full time in specialized hospital connected with university in Philadelphia area; opportunity for further education; qualifications at the university. For detailed information apply, Director Nursing, Graduate Hospital, 1815 Lombard Street, Philadelphia 46, Pennsylvania.

(Continued on page 192)



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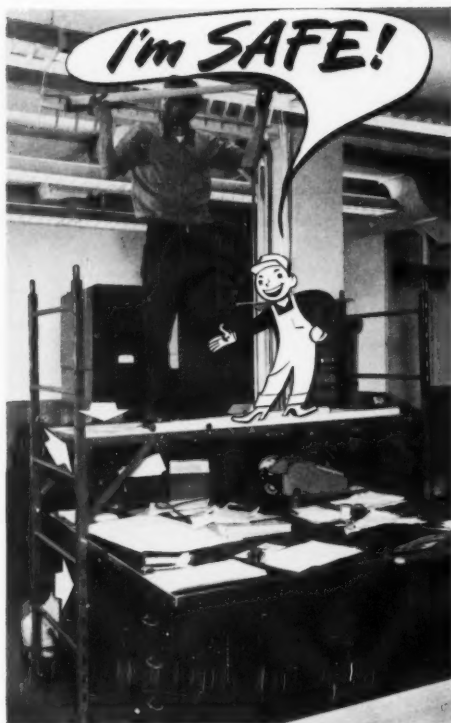
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**NURSES**—Suture; salary \$220 per month plus meals and laundry; if desired, maintenance is available at reasonable charge. Apply, Superintendent, New Rochelle Hospital, New Rochelle, New York.

**NURSES**—Registered; for head nurse and general duty nurse vacancies of non-sectarian general hospital staff; personnel policies meet approved standards; opportunity for progress offered. Contact Director of Nurses, Hospital of Saint Barnabas, 685 High Street, Newark 2, New Jersey.

**PHYSICIAN**—Male or female, registered in Pennsylvania, for general duty residency; excellent salary and full maintenance. Apply, Mr. Herman E. Goldberg, Administrator, Northern Liberties Hospital, Seventh and Brown Streets, Philadelphia 23, Pennsylvania.

**PHYSIOTHERAPIST**—To supervise department in 400-bed approved general hospital; modern equipment; 40-hour week; excellent working conditions; good beginning salary, maintenance available if desired. Apply, Personnel Director, The Christ Hospital, Mt. Auburn, Cincinnati, Ohio.

**SUPERVISOR**—Floor; and general duty nurse in a small approved sanatorium in a southern Michigan city; vacation with pay; sick leave; pension plan; six paid holidays; 40-hour week; full or partial maintenance; minimum salary \$220 and up, dependent upon ability and responsibility; experience in tuberculosis nursing desirable but not required. MO 53, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**SUPERINTENDENT OF NURSES**—69-bed general hospital; good salary; liberal personnel policies. MO 52, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**SUPERVISOR**—Maternity; 18 bassinets, building; satisfactory experience and/or post-graduate training; salary open; automatic increases, 40-hour week; 2 weeks vacation after first year. MO 52, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**SUPERVISOR**—Medical, surgical floor; 80-bed general hospital; salary open; automatic increases, 40-hour week, 2 weeks paid vacation after first year; experience and/or advanced training required. MO 53, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**SUPERVISOR**—Operating room; for 100-bed general hospital, located in southwest Virginia; excellent working and living conditions; salary open. Apply, Superintendent of Nurses, Pulaaki Hospital, Pulaaki, Virginia.

**SUPERVISOR**—Of nurses for 40-bed convalescent hospital for children under six years; experience in pediatrics preferred; attractive living quarters; state minimum salary desired. Write, Administrator, Children's Convalescent Home, 1731 Bunker Hill Road N.E., Washington, District of Columbia.

**SUPERVISOR**—Obstetrical; 250-bed hospital; post graduate work and experience required; salary and personnel policies attractive. Write, Postoffice Box 6558, Pittsburgh, Pennsylvania.

**SUPERVISOR**—Operating room; 250-bed hospital; post graduate work and experience required; salary and personnel policies attractive. Write, Postoffice Box 6558, Pittsburgh, Pennsylvania.

**SUPERVISOR**—Operating room; for Roper Hospital, Charleston, South Carolina. For further information apply to Ruth Chamberlin, Director of Nursing.

**SUPERVISORS**—Nurse; registered; for small units in mental hospital; must have three years' supervisory experience; eligible for Virginia registration; salary \$3092; 40-hour week; \$396 charged for complete maintenance; some private baths; periodic \$200 increase to \$3968; overtime paid for extra hours; two weeks' vacation, fifteen days' sick leave, both cumulative; six paid holidays; well organized nursing department; located in beautiful Shenandoah Valley, not far from Washington and Richmond. Apply, Isabel M. Reardon, R.N., Western State Hospital, Staunton, Virginia.

(Continued on page 194)

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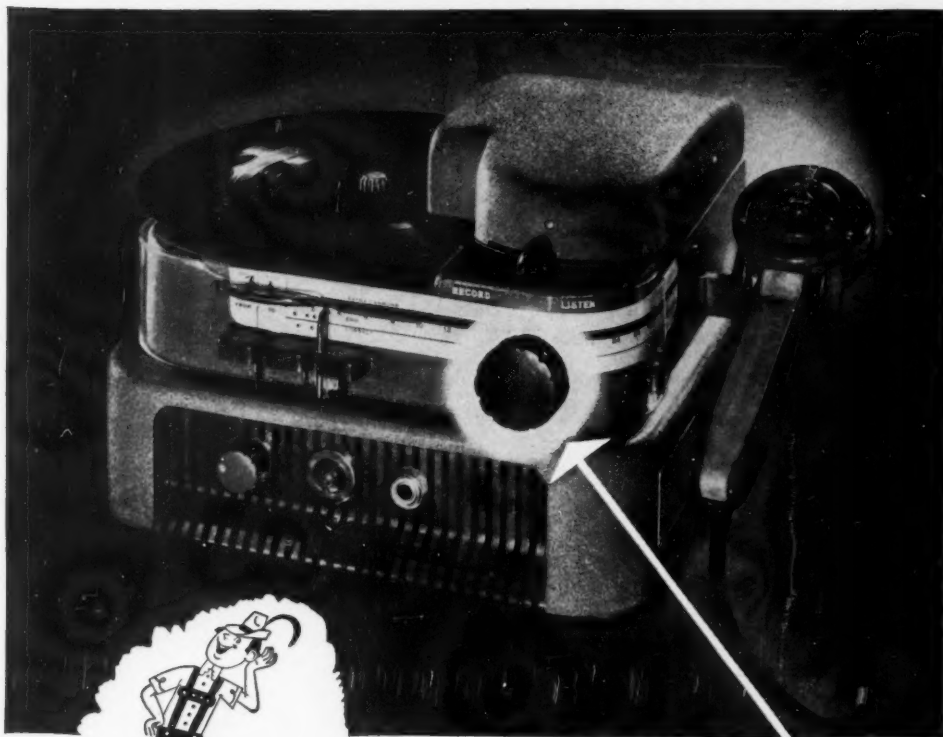
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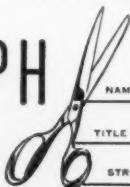
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**SURGEON**—Thoracic; assistant; 750-bed tuberculosis program, southern state, North American graduate; complete maintenance in addition to salary. MO 38, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**TECHNICIANS**—Medical laboratory; registered ASCP or eligible salary open. Burge Hospital, Springfield, Missouri.



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## MEDICAL BUREAU—Continued

Pacific Coast. (f) General hospital, 200 beds; building program; college town, 35,000; northwest. (g) Lay or medical administrator to serve as consultant in hospital and medical services, one of country's leading employees' organizations; preferably one interested medical care programs. (h) Medical or lay; important hospital, 700 beds, medical school affiliations; east. (i) Assistant director; 400-bed hospital, affiliated university medical school; midwest. (j) Assistant; fairly large general hospital; New England. (k) Assistant; 225-bed general hospital; town, 40,000; Rocky Mountains. MH12-1

**ADMINISTRATORS—NURSES**. (a) General hospital about to be completed; residential town, east; \$6000, maintenance. (b) Small general hospital; residential town; California. MH12-2

**ANESTHETISTS**—(a) New hospital, 150 beds; residential town near university city; southwest; percentage with minimum guarantee. (b) General hospital, fairly large size; resort town, Michigan; \$450, maintenance. (c) To administer anesthesia for group of specialists; university town, south; \$6000. MH12-3

**COLLEGE AND STUDENT HEALTH**—(a) Director, student health; 300-bed hospital; winter resort; northwest. (b) School nurse; public schools; southern California. MH12-4

(Continued on page 196)

## MEDICAL BUREAU—Continued

**DIETITIANS**—(a) Chief; qualified to organize and direct department, 400-bed general hospital; minimum, \$5000; east. (b) Dietitians to serve as food and assistant food administrators; large institution; salaries, \$4500-\$6000 and \$3600-\$4800 respectively; Pacific Coast. (c) Chief therapeutic and assistant dietitians; large general hospital; winter resort city; south. (d) Nutrition consultant; public health agency; midwest metropolis. (e) Chief; 350-bed hospital; university town, midwest. MH12-5

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**DIRECTORS OF NURSING SERVICE**—(a) University hospital, 600 beds; position independent administratively from school; minimum, \$5000, maintenance. (b) New hospital, 225 beds, currently under construction and affiliated hospital, relatively new, similar capacity; university city; opportunity continuing studies; Pacific Coast. (c) Associate director, nursing service; large teaching hospital; university center; east. MH12-7



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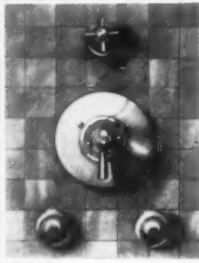
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**Enterprise**  
**STAIZE-CLENE**  
THE NEW MIRACLE DIRT REPELLING DISCOVERY

World's Only Paint Made With Patented **SYNCON**  
\*Made Under U. S. Patent No. 2,353,910

- Gives walls and ceilings 2 to 3 years of extra service—stays clean from 79% to 90% longer
- Lipstick, machine grease, mercurochrome and ink washes off without leaving a single trace of stain
- Calibrated colors — Da-Lite and Eye-Rest colors "rated" for light reflective values
- Complete line of Flat Enamel, Semi-Gloss Enamel and High-Gloss Enamel finishes — also Enamel Undercoater and Pigmented Primer Sealer

Compare the advantages STAIZE-CLENE gives you over any other paint. Weigh its dirt resistant qualities —note its better coverage—the fact that it goes farther —consider its high resistance to fumes—this will tell you why STAIZE-CLENE with Syncon has been hailed as the greatest improvement in paint in the last 20 years!

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**ENTERPRISE PAINT MFG. CO.**

Dept. SCMH-12  
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Please send me the FREE Manual—"How You Can Reduce Your Maintenance Painting Cost."

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Send for the FREE STAIZE-CLENE Manual—"How You Can Reduce Your Maintenance Painting Cost," and learn how you can make substantial savings with this unbeatable maintenance finish.

# classified advertising

## POSITIONS OPEN

### MEDICAL BUREAU—Continued

**MEDICAL RECORD LIBRARIANS**—(a) Head department, large, general hospital; New York City. (b) Qualified to organize and direct department in new hospital, 350 beds, affiliated with university medical center; residential town few miles from university center of 100,000. (c) Assistant; large teaching hospital; Pacific Coast. (d) Chief; competent organizer required; near Chicago; \$4800. (e) Take charge department, general hospital; small town, northern California; around \$4200. MH12-11

**EXECUTIVE HOUSEKEEPER**—New hospital, 225 beds, to be opened January; college town, south. MH12-8

**EXECUTIVE PERSONNEL**—(a) Hospital accountant or administrator with accounting background; important appointment with one of leading professional organizations. (b) Business manager; 150-bed hospital operated by group clinic; accounting background desirable. (c) Comptroller qualified to direct staff of twelve; general hospital, 300 beds; winter resort town, south. (d) Personnel director, 500-bed teaching hospital; university town; midwest. (e) Comptroller qualified assume administrative responsibilities; 350-bed hospital; east. MH12-9

### MEDICAL BUREAU—Continued

**FACULTY APPOINTMENTS**—(a) Assistant professor in nursing service administration qualified develop new curriculum in nursing service administration, and assistant professors or instructors in tuberculosis nursing and surgical specialties; university college of medicine. (b) Director of nursing program; school recently established by important college; challenging opportunity; Pacific Coast. (c) Assistant director, department of nursing, state university; south. (d) Educational director by state board; duties, surveying schools within state, improving standards; winter resort town, south. (e) Nursing arts, science and clinical instructors in medicine, surgery, pediatrics; large hospital expanding facilities; excellent school; California. (f) Educational director and nursing arts instructor; small school; near university center; midwest; \$5000 and \$4200, maintenance. MH12-10

**PHARMACISTS**—(a) Large general hospital; university city outside United States; unusual opportunity. (b) Chief, 300-bed hospital; university town, midwest. MH12-12

**SUPERVISORS**—(a) Chief, operating room; surgical hospital, principally major surgery; medical school affiliations; \$2600-\$3000 depending upon qualifications. (b) Obstetrical; one of leading hospitals, university city outside United States; although tropical country, climate mild. (c) Supervisor to take charge of small industrial hospital; southwest. (d) Obstetrical; new 225-bed hospital; college town;

(Continued on page 198)

### MEDICAL BUREAU—Continued

northwest; \$400-\$450. (e) Pediatric; one of leading hospitals, San Francisco area. (f) Chief operating room and departmental supervisors; large hospital operated by important clinic; east. (g) Orthopedic; new department, 300-bed hospital; college town, midwest. (h) Pediatric, EENT and psychiatric supervisors; new hospital, unit, university group; west. MH12-13

**STAFF NURSES**—(a) Surgical nurse; small hospital, 300 beds; Pacific Coast. (b) Scrub nurse; small hospital; resort town, north; \$3900, maintenance. (c) Surgical and general duty; small hospital; coastal town, Alaska. MH12-14

### INTERSTATE HOSPITAL AND PERSONNEL BUREAU

Miss Elsie Dey, Director  
332 Bulkeley Building  
Cleveland, Ohio

**DIRECTOR, NURSING SERVICE**—Assistant director; instructor and supervisors, for new 300-bed hospitals, south and southwest; excellent salaries.

**DIRECTORS, SCHOOLS OF NURSING**—(a) 300-450-bed hospitals, Ohio; open February; \$450-\$500. (b) 300-bed Sisters' hospital, central state; \$4500. (c) 200-bed hospital, Illinois.

## "Modern Hospital of the Year" Uses Air Conditioning & Refrigeration

The Comanche County Memorial Hospital at Lawton, Okla., chosen as the outstanding institution of 1950 by the Modern Hospital magazine, has 100 beds, serves 60,000 people.

Two Frick NEW "ECLIPSE" compressors, of 30 hp. each, provide air conditioning, and two other Frick machines cool four boxes for food service. Installation by the King Engineering Co., Frick distributors at Oklahoma City. Paul Harris, architect.

For your "project of the year" specify Frick cooling equipment.



DEPENDABLE REFRIGERATION SINCE 1867  
**Frick Co.**  
WYNESBORO, PENNA. U.S.A.  
Also Builders of Power Farming and Sawmill Machinery



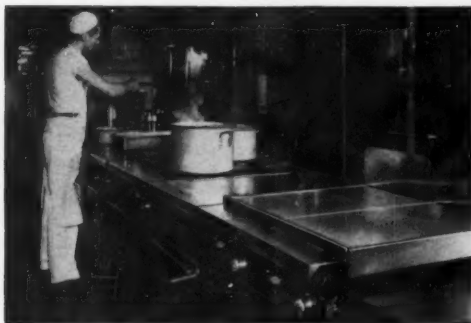
*Our Lady of Peace Hospital, Louisville, Ky.*

This new and modern hospital whose aim is to give their patients the very best in care, selected Vulcan-Hart cooking equipment on which to prepare their better than 600 meals daily.

Vulcan's completeness of line, coupled with Vulcan efficiency, has saved hospitals money the nation over by simplifying the kitchen planning

problem, and after operations commence, effecting real savings in fuel and food shrinkage.

Ask your dealer, or write to Vulcan-Hart Mfg. Co., 18 E. 41st, New York, N. Y., Dept. 14, for the facts which tell why Vulcan is ideal for every type of hospital installation.



**Vulcan-Hart**

"MAKES THE MOST AND THE BEST"

**VULCAN-HART MANUFACTURING CO.**

Pastories and General Offices: BALTIMORE 30, MD. • LOUISVILLE 3, KENTUCKY  
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In Canada: MOFFATS LTD., Weston, Ontario

HEAVY DUTY RANGES • BROILERS • BAKING OVENS  
ROASTING OVENS • RESTAURANT RANGES • GRIDDLES  
DEEP FAT FRYERS • FOOD WARMERS

# classified advertising

## POSITIONS OPEN

### MEDICAL BUREAU—Continued

**MEDICAL RECORD LIBRARIANS**—(a) Head department, large, general hospital; New York City. (b) Qualified to organize and direct department in new hospital, 350 beds, affiliated with university medical center; residential town few miles from university center of 100,000. (c) Assistant; large teaching hospital; Pacific Coast. (d) Chief; competent organizer required; near Chicago; \$4800. (e) Take charge department, general hospital; small town, northern California; around \$4200. MH12-11

**EXECUTIVE HOUSEKEEPER**—New hospital, 225 beds, to be opened January; college town, south. MH12-8

**EXECUTIVE PERSONNEL**—(a) Hospital accountant or administrator with accounting background; important appointment with one of leading professional organizations. (b) Business manager; 150-bed hospital operated by group clinic; accounting background desirable. (c) Comptroller qualified to direct staff of twelve; general hospital, 800 beds; winter resort town, south. (d) Personnel director, 600-bed teaching hospital; university town; midwest. (e) Comptroller qualified assume administrative responsibilities; 350-bed hospital; east. MH12-9

### MEDICAL BUREAU—Continued

**FACULTY APPOINTMENTS**—(a) Assistant professor in nursing service administration qualified develop new curriculum in nursing service administration, and assistant professors or instructors in tuberculosis nursing and surgical specialties; university college of medicine. (b) Director of nursing program; school recently established by important college; challenging opportunity; Pacific Coast. (c) Assistant director, department of nursing, state university; south. (d) Educational director by state board; duties, surveying schools within state, improving standards; winter resort town, south. (e) Nursing arts, science and clinical instructors in medicine, surgery, pediatrics; large hospital expanding facilities; excellent school; California. (f) Educational director and nursing arts instructor; small school; near university center; midwest; \$5000 and \$4200, maintenance. MH12-10

**PHARMACISTS**—(a) Large general hospital; university city outside United States; unusual opportunity. (b) Chief, 300-bed hospital; university town, midwest. MH12-12

**SUPERVISORS**—(a) Chief, operating room; surgical hospital, principally major surgery; medical school affiliations; \$3600-\$5000 depending upon qualifications. (b) Obstetrical; one of leading hospitals, university city outside United States; although tropical country, climate mild. (c) Supervisor to take charge of small industrial hospital; southwest. (d) Obstetrical; new 225-bed hospital; college town;

### MEDICAL BUREAU—Continued

northwest; \$400-\$450. (e) Pediatric; one of leading hospitals, San Francisco area. (f) Chief operating room and departmental supervisors; large hospital operated by important clinic; east. (g) Orthopedic; new department, 300-bed hospital; college town, midwest. (h) Pediatric, EENT and psychiatric supervisors; new hospital, unit, university group; west. MH12-13

**STAFF NURSES**—(a) Surgical nurse; small hospital, 300 beds; Pacific Coast. (b) Scrub nurse; small hospital; resort town, north; \$390, maintenance. (c) Surgical and general duty; small hospital; coastal town, Alaska. MH12-14

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Cleveland, Ohio

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**DIRECTORS, SCHOOLS OF NURSING**—(a) 300-450-bed hospitals, Ohio; open February; \$450-\$500. (b) 300-bed Sisters' hospital, central state; \$4500. (c) 200-bed hospital, Illinois.

(Continued on page 198)

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For your "project of the year" specify Frick cooling equipment.



DEPENDABLE REFRIGERATION SINCE 1882  
**Frick Co.**  
WAYNESBORO, PENNA. U.S.A.  
Also Builders of Power Farming and Sawmill Machinery



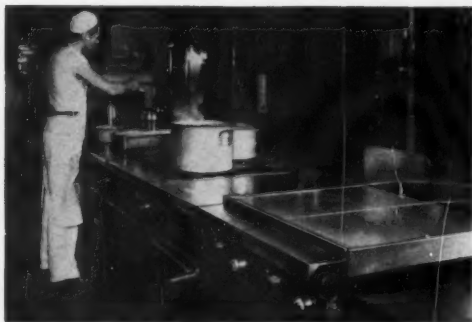
*Our Lady of Peace Hospital, Louisville, Ky.*

This new and modern hospital whose aim is to give their patients the very best in care, selected Vulcan-Hart cooking equipment on which to prepare their better than 600 meals daily.

Vulcan's completeness of line, coupled with Vulcan efficiency, has saved hospitals money the nation over by simplifying the kitchen planning

problem, and after operations commence, effecting real savings in fuel and food shrinkage.

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**Vulcan-Hart**

"MAKES THE MOST AND THE BEST"

**VULCAN-HART MANUFACTURING CO.**

Factories and General Offices: BALTIMORE 30, MD. • LOUISVILLE 3, KENTUCKY  
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HEAVY DUTY RANGES • BROILERS • BAKING OVENS  
ROASTING OVENS • RESTAURANT RANGES • GRIDDLES  
DEEP FAT FRYERS • FOOD WARMERS



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## POSITIONS OPEN

### INTERSTATE—Continued

**ASSISTANT DIRECTORS, NURSING SERVICE**—(a) 250-bed Ohio hospital; \$375; ideal living quarters. (b) Mid-western mental center; 400-bed hospital. (c) 300-bed eastern hospital.

**SUPERVISORS**—(a) Orthopedic; 200-bed hospital; central state; \$285. (b) Operating room; \$350. (c) Maternity; \$325; 300-bed modern hospital. (d) Auxiliary workers; 175-bed Ohio hospital.

**SUPERINTENDENTS**—(a) Registered nurse; 45-bed private hospital; Arizona. (b) 40-bed Minnesota hospital. (c) 50-bed, new hospital, Indiana.

**ADMINISTRATORS**—(a) 150-bed hospital; upper New York state. (b) 50-bed Ohio hospital. (c) 60-bed New Jersey hospital. (d) 65-bed hospital; Georgia.

**ASSISTANT ADMINISTRATORS**—(a) Accounting experience; 135-bed hospital; southern Ohio. (b) 300-bed hospital; New England. (c) Personnel director; large teaching hospital; Ohio.

**CHIEF ACCOUNTANTS**—(a) 200-bed hospital; south. (b) 400-bed eastern hospital; to \$7000.

### INTERSTATE—Continued

**EXECUTIVE HOUSEKEEPERS**—(a) 250-bed hospital; Pennsylvania. (b) 170-bed hospital; southwest. (c) Assistant; 300-bed new modern hospital; Ohio.

**PHARMACISTS**—(a) Chief; Pennsylvania. (b) Assistant; Michigan. (c) 200-bed hospital; Florida.

**RECORD LIBRARIANS**—East; mid-west; south.

### MEDICAL PERSONNEL EXCHANGE

**Nellie A. Gealt, R.N., Director**  
4707 Springfield Avenue  
Philadelphia 43, Pennsylvania

**ANESTHESIOLOGIST**—Certified or eligible; 150-bed hospital; start \$12,000 or better.

**ASSISTANT DIRECTOR OF NURSING**—Children's hospital; \$4500; 40-hour week.

**DIRECTOR OF DIETETICS**—280-bed hospital; \$385; partial maintenance.

**EXECUTIVE HOUSEKEEPER**—275-bed hospital; western Pennsylvania.

**RECORD LIBRARIANS**—(a) Head; 500-bed; New York City area. (b) Assistant; large hospital, southwest. 40-hour week.

**PHYSIOTHERAPIST**—Head; new 285-bed general hospital; January 1.

### MEDICAL PERSONNEL EXCHANGE—Continued

**SOCIAL DIRECTOR AND ASSISTANT**—New 200-bed hospital; January 1.

**SUPERVISOR**—Large new and modern hospital; nursing department well organized; no age limit up to 65; will consider a nurse with a slight physical handicap.

**ASSISTANT SUPERVISOR**—Cerebral palsy institute; mature woman; \$225 plus full maintenance.

**LABORATORY TECHNICIAN**—Male or female; small hospital; university city; well organized department; \$300.

No charge for registration

### BUSINESS AND MEDICAL REGISTRY (Agency)

**Elsie Miller, Director**  
610 South Broadway, Room 1105  
Los Angeles 14, California

**ANESTHETIST**—Private general hospital; 250 beds; Utah; \$400.

**DIRECTOR OF NURSES**—Private general hospital; 75 beds; southern California; \$300 and apartment; 40-hour week.

**ASSISTANT DIETITIAN**—Therapeutic; for 75-bed general hospital near Los Angeles; \$250; 40-hour week.

(Continued on page 200)



Commemorating our 60th Anniversary

**THE POWERS REGULATOR COMPANY**

New Factory and General Office Building: 3400 Oakton Street, Skokie, Ill.

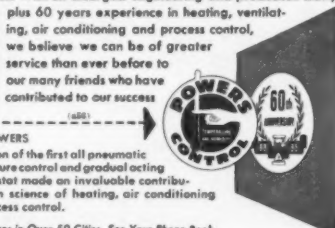
### World's Most Modern Factory Producing Automatic Temperature and Humidity Control

... to meet the greatly increased demand for Powers products and to give you better controls, better deliveries and better values ... these advantages are possible with our large new plant and modern production facilities. With an enlarged engineering and production staff,



WILLIAM PENN POWERS

... with his invention of the first all pneumatic system of temperature control and gradual acting vapor disc thermostat made an invaluable contribution to the modern science of heating, air conditioning and industrial process control.



Offices in Over 50 Cities. See Your Phone Book.

## STIMULATE FUND RAISING

Plaques & nameplates in bronze, aluminum or plastic have been proved the ideal, dignified and most effective way to raise funds for hospitals. By acknowledging contributions in this permanent manner you encourage future donors. Why not write us now for illustrations and prices. You'll be pleased by this economical and attractive way to give permanent recognition.



Style B

Solid cast aluminum or bronze tablet. Raised letters in bold relief contrasting with stippled oxidized background.



Style P

Faultless engraving on laminated phenolic plastic. Your choice of white letters on Mahogany, Walnut, Gray or black background.

### A FEW OF OUR MANY HOSPITAL ACCOUNTS\*

\*Baton Rouge Hospital      \*Kings Daughters Hospital  
\*Cerebral Palsy Hospital      \*Mt. Sinai Hospital  
\*Anderson County Hospital      \*Sloan Kettering Institute

\*Exact addresses furnished on request

"BRONZE TABLET HEADQUARTERS"

**United States Bronze Sign Co., Inc.**

570 Broadway

Dept. MH

New York 12, N. Y.

# AMERICAN-Standard

First in heating...first in plumbing

## It's AMERICAN-Standard for both heating and plumbing at Montrose Medical Center

● The new Medical Center in Montrose, Colorado, followed the trend of outstanding institutions all over the country and installed American-Standard heating equipment and plumbing fixtures throughout.

American-Standard products meet the most rigid hospital requirements. They're designed to provide utmost comfort, safety and relaxation

of patients, utmost convenience in use by hospital personnel. And they're sturdily constructed, easy and economical to maintain.

Check the complete American-Standard line when you build, remodel or make a replacement. There is a wide variety of types and models of plumbing fixtures and heating equipment designed to meet every hospital need.



Architects: Fisher & Fisher, Denver, Colorado.

Heating engineer: Marshall & Johnson, Denver, Colorado.

General contractors: Marvin Gill, Montrose, Colorado.

Wholesale distributor: Biggs-Kurtz Co., Grand Junction, Colorado.

Heating and plumbing contractor: Lis & Anderson, Montrose, Colorado.



**SMART, RADIATRIM PANELS** in the Montrose Medical Center lobby provide both superior heating comfort and outstanding good looks. Radiatrim Panels allow complete freedom of room decoration... the entire floor area is free. And the space-saving panels provide an even blanket of warmth, varying only slightly from floor to ceiling. Adaptable to either forced hot water or two-pipe steam heating system.



**THE HEATING SYSTEM** of the Montrose Medical Center is fired by this Exbrook Boiler, assuring an abundance of heat throughout the building. Designed for automatic firing with either coal or oil, the Exbrook is noted for its dependable fuel-saving operation. It is durably constructed of cast iron and has a smooth, Forge Red jacket which is heavily insulated to prevent heat loss.



**THIS WASHROOM** in a dental clinic of the Medical Center features a streamlined Marledge lavatory and a Madera water closet. Made of non-absorbent genuine vitreous china, they will retain their good looks indefinitely. The Marledge has a handy shelf back, built-in soap dishes, non-tarnishing Chromard fittings. The Madera's siphon jet water action assures thorough, quiet flushing.

American Radiator & Standard Sanitary Corporation, P. O. Box 1226, Pittsburgh 30, Pa.

*Serving home and industry*

AMERICAN STANDARD • AMERICAN BLOWER • ASME CABINET • CHURCH SEATS • DETROIT LUBRICATOR • KEWANEE BOILER • ROLL HEATER • TONKAWANJA IRON

# classified advertising

## POSITIONS OPEN

### BUSINESS AND MEDICAL REGISTRY— Continued

**MEDICAL RECORD LIBRARIAN**—County hospital; 250 beds; central California; new air-conditioned building, new equipment; \$285, partial maintenance; 40-hour week.

**NURSING ARTS INSTRUCTOR**—Degree and teaching experience; county hospital near San Francisco; \$350; 40-hour week.

**PEDIATRIC SUPERVISOR-INSTRUCTOR**—Degree and supervising experience essential; \$300; 40-hour week; near San Francisco.

**SHAY MEDICAL AGENCY**  
Blanche L. Shay, Director  
55 East Washington Street  
Chicago 2, Illinois

**ADMINISTRATORS**—(a) Southwest city of 70,000; 100-bed hospital; building program nearly completed to increase to 200 beds; need man capable of supervising building program to completion and to direct reorganization

### SHAY—Continued

necessary to operate hospital at a high rate of efficiency. (b) West; 250-bed teaching hospital affiliated with well-known university; beautifully scenic country and ideal year around climate. (c) South; brand new, modern 150-bed hospital, air conditioned throughout; will be ready for occupancy early in 1952 but need man now to direct completion of building and set up system of operation, etc.; located in lovely southern city of 20,000. (d) Assistant administrator; Chicago; large, fully approved hospital—fine opportunity. (e) Foreign; company owned hospital of large American company located in large, modern city; must be in early thirties, with good hospital administrative experience; wonderful opportunity.

**DIETITIANS**—(a) Chief; east; 220-bed hospital in large city; prefer Master's Degree; \$6000. (b) Chief; east; 400-bed hospital; ADA; proven ability in organizing and supervising dietetic department in a general hospital of 200 beds or more; department well staffed; \$6000. (c) Northeast; chief; good administrative experience; ability to organize, plan and direct work of a large number of employees is as important as technical knowledge; staff consists of 52, including one administrative, one teaching and three therapeutic dietitians; \$7200. (d) Therapeutic; modern 350-bed hospital, fully approved. ADA; good experience in special diets; \$5000 plus complete maintenance.

(Continued on page 202)



OUR 55th YEAR

**WOODWARD**  
Medical Personnel Bureau  
FORMERLY ANNE'S

3rd floor • 185 N. WABASH AVE.  
CHICAGO • 1  
• ANN WOODWARD • Director

If none of the following opportunities meets your requirements, let us prepare an individual survey for you. Please send for an analysis form. Strictly confidential.

**ADMINISTRATORS**—(a) Medical; 250-bed hospital and tuberculosis sanatorium; FACCP desirable but not necessary; delightful west coast locality; about \$12,000 plus attractive residence. (b) Lay; 300-bed beautifully equipped teaching hospital affiliated important medical school; noted medical, educational and cultural city 500,000; central. (c) Direct medical, surgical and administrative activities, 150-bed tuberculosis sanatorium; college and shore resort city 150,000; middle Atlantic. (d) Lay or medical; superintendent, 250-bed teaching hospital; also administer affiliated county infirmary for indigents; state capital city; west. (e) Medical; superintendent; 500-bed institute for the care and training of feeble-minded; requires recognized psychiatrist with institutional experience; furnished home with complete maintenance for family; New England. (f) Medical; assistant superin-

## Need New Scullery Sinks?

*Just Line*

Sinks Last Years Longer . . .  
Cost Less in the Long Run . . .

When you install a new Scullery Sink, insist upon these three important features:—

- 1 Electrical Welding throughout for extra strength and long service
- 2 Scientific construction of extra heavy gauge steel—14 gauge stainless or 12 gauge hot dip galvanized—for sturdiness and durability
- 3 Sanitary Seamless Design and styles to meet state and federal health regulations.

And because all three of these important features are built into each and every JUST LINE Scullery Sink, they not only meet every Sanitary regulation, but they last many years longer.

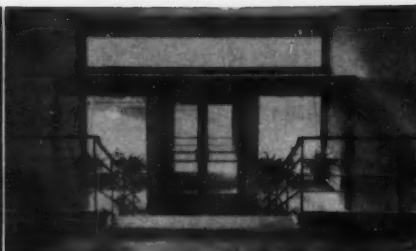
### 24 STANDARD SIZES

JUST LINE Scullery Sinks are supplied in one, two and three compartment types with or without integral or detachable drainboards and with or without back splashes. Also in special sizes to meet individual requirements. Write today for Illustrated Literature M-1251 or send us your specifications.

**Just Manufacturing Co.**

4610-30 W. 21st Street, Chicago 30, Illinois

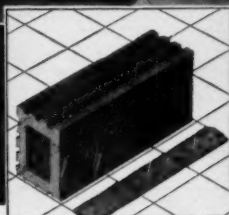




Interior views showing NATCO Ceramic Glazed Structural Facing Tile (Vitritle) used in LLOYD ST. JOSEPH HOSPITAL, Menominee, Michigan. Architect—Harry W. Gjelsteen, Menominee, Michigan. Contractor—Proksch Construction Co., Iron River, Michigan.



LLOYD ST. JOSEPH HOSPITAL  
walls are permanently  
cheerful and colorful  
because they are **NATCO**  
GLAZED STRUCTURAL FACING TILE



Health-stimulating attractiveness was achieved in this fine modern Michigan hospital by using NATCO Ceramic Glazed Structural Facing Tile in Ivory and Green. And, with this enduring beauty there is no need for future painting or refinishing—there is no maintenance expense other than occasional washing with soap and water. Besides, the walls are germ-proof, firesafe and strong.

In addition to NATCO Ceramic Glazed Structural Facing Tile, NATCO Bakup Tile and NATCO Clay Partition Tile were used in the building. This is another economy advantage . . . you can obtain every type of tile needed from a single source. Every piece of tile is stamped NATCO—your assurance of quality. Write for a copy of NATCO CATALOG SA-50.

**MODULAR COORDINATION**  
Tile and 12 inch ruler at right are laid on grids made up of 4 inch squares. The 4 inch module unit of measure is the basis of modular coordination for all building materials and equipment.



## NATIONAL FIREPROOFING CORPORATION

GENERAL OFFICES: 327 FIFTH AVENUE • PITTSBURGH 22, PA.

Branches: New York • Syracuse • Detroit • North Birmingham, Alabama  
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"The Quality Line Since 1889"



**Ruggle Blocks**  
Prevent Water Seepage  
4" x 5 1/2" x 12" Nom. Size



**Speed-A-Border Tile** for  
Backing Brick Faced Walls  
12" long Varying Heights



**Ceramic, Clear  
Glazed Vitrile** 5 1/2" x 12"  
Nom. Face Size



**Ceramic Glazed Vitrile**  
8" x 16" Nom. Face Size



**Non-Loadbearing Tile, Smooth  
and Unglazed, 12" x 12" Face**  
In Standard Wall Thicknesses



**Buff Unglazed, Manganese  
Spinel Glazed, Red  
Tinted (Dr.) Speedwall Tile,**  
5 1/2" x 12" Nom. Face Size

# classified advertising

## POSITIONS OPEN

### WOODWARD—Continued

tendent; large state psychiatric hospital; requires Diplomate, American Board of Neuro-psychiatry and Psychiatry; substantial salary, excellent housing and maintenance; Pacific Northwest. (q) Lay; 200-bed brand new home for the aged; requires one with interest in and knowledge of geriatrics, Jewish cultural and religious backgrounds and orthodox Jewish practices; large grounds, well-situated in heart of eastern metropolis. (h) Medical director; assistant; 175-bed general and tuberculosis hospital; excellent equipment and facilities; to \$8000 or more with maintenance; should have at least one year residency in internal medicine or tuberculosis; excellent city \$90,000; east-north central. (i) Lay; 200-bed general, voluntary, fully approved hospital; also administer adjoining home for aged and new smaller branch situated in Florida; main hospital Chicago area; unusual appointment. (j) Lay; 180-bed hospital, general in character; much sought after island of American dependency; considered tropical though climate mild; substantial initial salary. (k) Lay; 175-bed general hospital; excellent facilities and nurses' training school; sunshine resort city 100,000; Florida. (l) Lay; 150-bed general hospital; town 150,000; Michigan. (m) Lay; 100-bed, voluntary, general hospital; university town 40,000; east. (n) Lay; 160-bed general, voluntary hospital; Chicago area.

### WOODWARD—Continued

(o) Lay; 95-bed general hospital; Minnesota. (p) Lay; excellent 100-bed general hospital; beautifully situated near the Imperial Valley section of California. (q) Lay; brand new 85-bed Hill-Burton hospital; excellent medical staff; smaller town; Illinois.

### ADMINISTRATIVE STAFF APPOINTMENTS

—(r) Comptroller; 500-bed, fully approved, general hospital; complete charge entire financial department; should be familiar with inventory and stock control records and hospital operations; substantial salary; city 100,000; east. (s) Chief accountant and administrative assistant; brand new 200-bed Hill-Burton general hospital; lovely old south town 35,000; southeast. (t) Comptroller; complete charge department of 12 employees; 200-bed general voluntary hospital; lovely resort town 60,000; Florida. (u) Personnel manager; large university hospital; 700 employees; should have experience in hospital field; lovely residential suburban town of 70,000; Chicago area. (v) Business manager; excellent group distinguished physicians; clinic serves as medical center for huge area; midwest. (w) Business manager; 180-bed general, voluntary hospital expanding to 300 beds; large California city. (x) Comptroller-chief accountant; man in early 30's preferred; department has fine, younger staff; 200-bed general, voluntary hospital; excellent residential, college town 20,000 very near New York City.

### WOODWARD—Continued

ADMINISTRATORS—NURSES. (a) Small hospital-clinic, vicinity California national parks; (b) 30-bed Indiana hospital; \$4000, maintenance. (c) 35-bed hospital; town 12,000, vicinity Boston; \$4000, maintenance. (d) Assistant; 35-bed general hospital; Iowa. (e) Smaller hospital, vicinity Reno; \$4300, maintenance. (f) 50-bed general hospital; Buffalo area.

ANESTHETISTS—(a) 80-bed new hospital; Florida resort city; \$4200, maintenance. (b) 200-bed approved hospital; central Iowa; \$4800, maintenance. (c) 200-bed hospital; beautiful Potomac river valley; \$4500, maintenance. (d) 100-bed hospital; northwestern New York; \$4800, maintenance. (e) 200-bed approved hospital; city 75,000, adjacent southern educational center; \$6000. (f) New modern clinic-hospital; Texas town 20,000; \$5400. (g) Large general hospital; southeastern state capital; staff of five; \$5000.

DIETITIANS—(a) Complete charge dietary department, large hospital; unusually attractive location Long Island Sound, adjacent New York City; to \$5200. (b) 300-bed hospital, eastern university town; \$6000. (c) Unusually well-equipped psychiatric institution, good western location; \$5000. (d) Large teaching hospital; west coast university center; top salary. (e) 250-bed modern hospital; southeastern city 40,000, vicinity southern resort and educational centers; \$4800.

(Continued on page 204)



## IDENTITY DIGNITY FRIENDLINESS

Identify nurses, aides, dietitians, technicians and others by name or title or both with these inexpensive plastic name pins. Wide variety of color combinations. Narrow pin  $\frac{3}{8}$ ", takes one line;  $\frac{3}{4}$ " width takes two lines, name and title. Sample, prices and details on request. Write today to

**STERLING** NAME TAPE COMPANY  
WINSTED, CONNECTICUT

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## The Glove Master

dries and powders  
surgical  
gloves  
automatically

- saves time
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The Glove Master will help you meet the emergency of reduced personnel. It will dry and powder surgical gloves in a small fraction of the time required by hand methods.

Write TODAY for Illustrated Circular.

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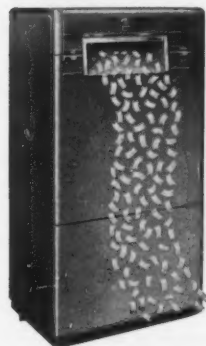
# SLASH YOUR ICE COSTS *Always*

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The York-FlakIce Machine and the York Automatic Ice Maker (that makes the famous Yorkube "with the hole") will slash your ice bills

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**York's unique FlakIce Machine** automatically produces up to a ton or more a day of small, thin, easy-to-handle ice flakes, pure as the water your patients drink. FlakIce Frosty Ribbons are ideal for ice packs, ice anesthesia, cold therapy, "bains-marie," and many other hospital uses. Produced *where* you want it *when* you want it.

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## CHECK THESE YORK FEATURES

- No hauling, hosing or chipping required.
- Ice from each machine is stored in its own large, sanitary, dry bin—no costly waste due to melting.
- Need for large storage facilities eliminated.
- Sanitary, air-free, sediment-free ice—made automatically from running water.
- Supply hazard eliminated. These compact York machines—located at the points of greatest convenience for your staff—are busy at work on your premises days, nights, weekends, holidays. And their record of dependability is truly unmatched.



The big advances come from

# YORK

Headquarters for—Refrigeration and Air Conditioning

# classified advertising

## POSITIONS OPEN

### WOODWARD—Continued

**DIRECTOR OF NURSES**—(a) 200-bed, college affiliated hospital, California resort city. (b) 500-bed hospital; eastern educational center; \$5500 up. (c) 200-bed pediatric, university teaching unit; northern New York; \$6000, maintenance. (d) 150-bed general hospital; Ohio city \$5,000; \$5000, maintenance. (e) 250-bed hospital; east central college town; \$5400 up. (f) Small, new Texas hospital; \$5000. (g) 200-bed, new Virginia hospital; \$5000, maintenance. (h) Assistant; 300-bed hospital; Atlantic Ocean resort city; \$3500, maintenance. (i) Assistant; large, eastern tuberculosis hospital; \$4500 increasing to \$5700.

**FACULTY APPOINTMENTS**—(a) Director nursing education; 500-bed psychiatric hospital; excellent east coast location; \$4500 up. (b) Clinical instructor; 150-bed hospital; Florida resort city; \$3600, maintenance. (c) Pediatric nursing, southern state college; to \$5000. (d) Nursing arts instructor; southeastern university hospital; \$4900 up. (e) Science instructor; college affiliated hospital; good east central location; \$4500 yearly. (f) Psychiatric instructor; southern state college; \$3400-\$5000.

### WOODWARD—Continued

**MEDICAL RECORD LIBRARIANS**—(a) Large approved hospital; prosperous fruit growing community, vicinity California capital; 5-day 40-hour week. (b) Assistant; large, approved teaching hospital; Colorado state capital; opportunity for advancement. (c) Chief; large, approved hospital; exciting western location surrounded by mountains; \$3600. (d) Medium, approved, general hospital, attractive Shenandoah Valley locale, near Charlottesville, North Carolina. (e) Medium, approved, general hospital, recently completed expansion program; new record department with fine facilities; eastern Pennsylvania. (f) Medium, approved, general hospital, modern facilities; Chicago. (g) 117-bed, fully approved hospital; beautiful community and city; excellent salary. Hawaii. (h) Large, approved, general hospital; residential Long Island Sound locale; \$275.

**PHARMACISTS**—(a) Modern, 200-bed hospital; Florida resort city; open. (b) Midwest university hospital; excellent personnel policies. (c) Large Texas teaching hospital; educational center; \$3600 up. (d) 100-bed Illinois hospital, vicinity state capital; \$4800. (e) New 200-bed Virginia hospital; \$5400.

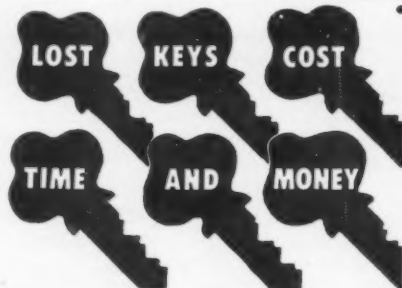
**PHYSIOTHERAPISTS**—(a) New California hospital with polio foundation; San Diego area; \$4000-\$4200. (b) 250-bed Ohio hospital, college town, 50,000; interesting cerebral palsy work; to \$4200. (c) Texas medical center and resort city; \$4200-\$4800.

(Continued on page 206)

### WOODWARD—Continued

**SCIENTISTS**—(a) Bacteriologist; medical technologist well qualified bacteriology; take charge department; large approved Los Angeles Hospital; \$3300 up; California license required. (b) Biochemist; medical technologist well qualified, experienced, biochemical work; take charge department large midwest hospital; salary \$4200, Masters Degree required. (c) Hematologist; for interesting research work; large, approved Chicago hospital; good location with excellent transportation to better shopping and recreational facilities; \$3600, maintenance. (d) Pharmacologist; Doctorate in Pharmacology required; excellent research appointment, well known pharmaceutical firm; excellent eastern location; salary to \$5500 for qualified person. (e) Physiotherapist, registered; for small, modern hospital, California city 25,000, San Francisco Bay area; 5-day 40-hour week; \$3300, maintenance. (f) Research biochemist for independent cancer research; large hospital, midwest metropolis; Master's Degree required; minimum salary \$800 per month.

**TECHNICIANS**—(a) Chief technician; college graduate well qualified chemistry, 150-bed New York hospital, well staffed department; adjacent lake resort community; \$2600, maintenance. (b) Laboratory supervisor; registered; experienced; assume responsibility large department substantial New York hospital; attractive Hudson River location; \$4200 up. (c) X-ray and laboratory technician; well qualified laboratory; well-established clinic, California college town; excellent group of eleven specialists; \$3300-\$3600.



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**FAIRBANKS-MORSE,**  
a name worth remembering

# Your Heinz Man *works profit magic!*



## Let Him Show You How To Switch More Customers To High-Profit Dishes!

**Y**OUR HEINZ MAN is far more than just a salesman. He is a restaurant service specialist trained and equipped to help you with all kinds of food and operating problems.

- Among other things, he will gladly provide you with a complete merchandising service spe-

cially created to influence your customers to order dishes on which you make the most!

- Next time your Heinz Man calls, ask him to put his *profit magic* to work for you. This free service is only one of *many* ways your Heinz Man is prepared to serve you. Make it a point to take advantage of them *all!*

Ask Your HEINZ Man About—

# HEINZ VARIETIES

YOU KNOW THEY'RE GOOD BECAUSE THEY'RE HEINZ!



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## POSITIONS OPEN

### WOODWARD—Continued

UNUSUAL OPPORTUNITIES—(a) Chief orthopedic nursing consultant; southwestern state capital; to \$4500. (b) Nurse-stewardess, Chicago-California railway line; \$3,500 yearly. (c) Clinic nurse; two-man group, pleasant Chicago suburban community. (d) Office nurse; knowledge x-ray and general office desired; to \$3500. (e) Day nurse; supervise small Indiana hospital, vicinity Fort Wayne; \$2400, maintenance. (f) Public health nurse; Michigan resort region; \$4200 up.

### HOSPITAL PERSONNEL BUREAU

Charles J. Cotter, Director  
Professional Arts Building  
Hagerstown, Maryland

ANESTHESIOLOGIST—M.D., \$10,000-\$14,000.

NURSE ANESTHETISTS—\$4,200.

PHARMACIST—\$3,600-\$4,800.

CHIEF DIETITIAN—ADA; \$2,700-\$3,000.

NURSES—Surgery, obstetrical, central supply, staff; \$2280-\$2700.

Liberal perquisites. Openings New Jersey to Virginia. Other openings. Supply complete information, first letter.

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Professional Counseling & Placement  
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For local counseling and placement consult your state nurses' association. For national referral consult ANA, PC&PS, Inc. Branch Office, 8 South Michigan Avenue, Chicago 2, Illinois.

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We have many good openings for Directors of Nurses, Instructors, Supervisors, Dietitians, Medical Technicians, Record Librarians and Staff Nurses. If you are looking for a position, please write us.

(Continued on page 208)

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7 East 42nd Street  
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If you are seeking a position or personnel—please write. Gladys Brown, Owner-Director. We Do Not Charge a Registration Fee.

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Medical and Social Service Personnel.  
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Consultation, Survey, and Organization  
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HOSPITAL SUPPLY SALESMAN  
Can offer top, money-making line of Hospital  
Garments. Write fully. SHARWARD MANU-  
FACTURING COMPANY, 2655 South Wabash  
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Hundreds  
of Hospitals  
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LAKE SIDE  
Stainless Steel TRAY TRUCKS



ONE person serves many patients quickly and easily—provides warmer food, faster turn-over of trays. Model 355 above has five 18"x31" shelves. . . . Model 433 at left has six 21"x35" shelves. Four 3-shelf models also available.

See Your Jobber or Write

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KENWOOD  
HOSPITAL Blankets

Discuss your blanket problems with your  
Kenwood representative, or write direct to the mill  
for swatches, prices and complete information.

KENWOOD MILLS, Contract Department, Rensselaer, N. Y.

**Steadily  
assimilated  
carbohydrates**

Widespread clinical experience has established Cartose as a valuable modifier of milk in any form.

Cartose contains a mixture of carbohydrates—dextrins, maltose and dextrose—each having a different rate of assimilation.

Added to the infant's formula, Cartose assures a steady absorption of carbohydrate with a corresponding low rate of fermentation and low incidence of digestive disturbances.

**CARTOSE**

MIXED CARBOHYDRATE in easy-to-use liquid form

Instantly soluble  
No nipple clogging

BOTTLES OF 1 PINT

Write for formula blanks

No gumming  
No caking

Milk Diffusible Vitamin D<sub>2</sub>  
**DRISDOL**

IN PROPYLENE GLYCOL

Sterile clear solution of pure crystalline vitamin D<sub>2</sub>—10,000 units per gram. Bottles of 5 cc., 10 cc. and 50 cc.

**DRISDOL**  
with VITAMIN A  
Now also milk diffusible

10,000 units of vitamin D, 50,000 units of vitamin A per gram. Bottles of 10 cc. and 50 cc.

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We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

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For price and further information write, Gregson Hot Springs Company, Gregson, Montana.

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Motor Driven Beaumont Ash Hoist, Capacity 19 tons per hour at 50 ft. lift, with skip bucket operating at cable speed of 75 ft. per minute. Write Purchasing Agent, Orange Memorial Hospital, Orange New Jersey, for particulars.

Castle Autoclave Model No. 20125, clinic or small hospital size. In new condition. Dr. Joseph G. Riley, Lovelace Clinic, Albuquerque, New Mexico.

1 Bausch and Lomb, Model GBPT, horizontal, photomicrographic camera and microscope with attachments. Purchased in 1941. Accommodates up to 8 x 10" plates. Bargain for one interested. Write for full information, Delaware Hospital, 14th and Washington Streets, Wilmington, Delaware.

29 Simmons Hospital Screens

4 Used Hess Infant Oxygen Incubators

1 Holly Fracture Table

2 Oxygen Tents—Ice Type

MacNeal Memorial Hospital, 3249 South Oak Park Avenue, Berwyn, Illinois.

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## WASHINGTON UNIVERSITY School of Nursing GRADUATE NURSE EDUCATION

Programs for 1951-52

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Arts and Skills in Nursing  
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Leading to the degree of Master of Science in Nursing:  
Psychiatric Nursing

For further information write to the Director, Washington University School of Nursing, 414 South Kingshighway, St. Louis 10, Missouri.

## SCHOOL FOR LABORATORY TECHNICIANS

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THE PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and a stipend of \$60 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

LOS ANGELES COUNTY GENERAL HOSPITAL SCHOOL OF NURSING offers a twelve weeks course in premature infant nursing to graduate nurses. The University of Southern California will grant up to six units of credit to those nurses who desire it. Course includes formal instruction, clinical experience in unit technique, teaching and public health experience. For further information write to Director, School of Nursing, Los Angeles County General Hospital, 1200 North State Street, Los Angeles 33, California.

THE MARGARET HAGUE MATERNITY HOSPITAL. The largest hospital in the country offers the following to registered, professional nurses of accredited schools:

### Four Months' Course:

Included are obstetric lectures, nursing classes, techniques, laboratory science, nutrition, mothers' health and socio-economic aspects. Supervised experience is given in antepartal, intrapartal, postpartal and newborn infant care with a minimum of twenty-five hours of clinical instruction. Students may elect one month's experience in premature nursery, formula room, isolation, antepartal or clinic and field service.

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Following the above program, a two months' course is offered to students who have demonstrated potentialities for head nurse responsibilities. It includes instruction in principles and methods used in clinical teaching program and ward management. Students plan and conduct their program of clinical instruction with the head nurse and serve as assistants. They are directed and supervised by the instructor of the course.

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SLIDE FIRE ESCAPES  
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And the new Class 21's Built-In Adding Machine feature can be used at any time without disturbing the locked-in cash register records. It saves valuable time, and prevents costly mistakes in your daily figure-work. Its electric operation is fast and easy. The standard keyboard enters ciphers *automatically*, and has easy key touch.

Phone your nearest National office today for a demonstration. Or, write to the Company at Dayton 9, Ohio.

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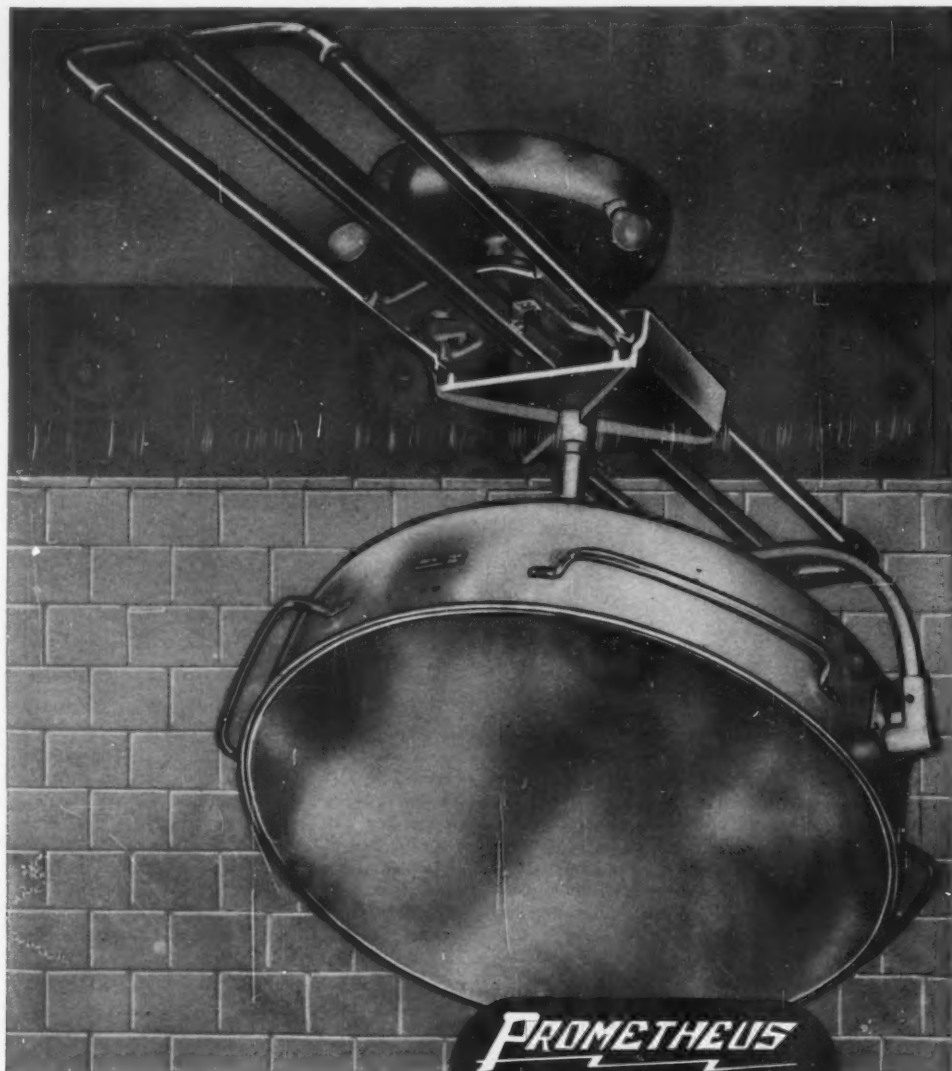




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Rotary track mounted, there is never any need to move operating table to bring the light into proper position for the operation, whether it be an appendectomy, mastectomy, cholecystectomy, etc. Special scientific filters provide heatless, shadow-free, color-corrected light.



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◆ The man who fell on the slippery floor?

or

◆ The man who owned the building?

Everybody laughs when a fat man falls.

But it isn't funny to the fat man. Nor to the thin man or the slim woman. Or whoever else breaks a bone, falling on a slippery floor.

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**LEGGE SYSTEM**  
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... and what soap can give more?

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*Construction*, which provides big savings these three ways:

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*In construction products* **CECO ENGINEERING** *makes the big difference*

# What's New for Hospitals

DECEMBER 1951

Edited by BESSIE COVERT

TO HELP YOU get information quickly on new products described in this section, we have provided the convenient Readers' Service Form on page 236. Check the numbers of interest to you and mail the coupon to the address given on the form. If you wish other product information, just list the items and we shall make every effort to supply it.

## Gas-Heated Ironer



The latest engineering developments and safety features have been incorporated in the new American gas-heated flatwork ironer. It is designed for use with either natural, manufactured or bottled gas, is ruggedly built and streamlined in design. The ironer features a thermostatic control which automatically throttles down the gas when the ironing cylinder reaches a preset temperature, preventing overheating. Automatic safety valves shut off gas to the ironer should the pilot light go out and automatically shut off gas to the burner when the ironer is not operating or in case of power failure.

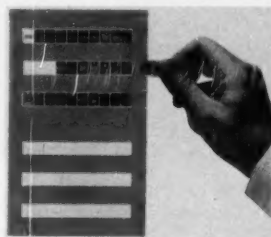
The new ironer has five padded rolls, rotating over an ironing cylinder heated by a full-length, drilled-pipe burner which is baffled to maintain the gas flame at a constant, uniform height for most efficient transfer of heat. Easy-action treadles apply and release ironing pressure, which is recorded by a visible indicator. A simple lever controls ironing speed and a clearly visible ironing speed indicator is provided for regulating ironing speed according to the type of work being ironed. The ironer is available in 60, 85 and 110 inch sizes with same side feed and delivery. A deflector and delivery ribbons for returning linens to the rear of the ironer can be furnished as optional equipment. The American Laundry Machinery Co., Dept. MH, Cincinnati 12, Ohio. (Key No. 666)

## Kard-a-Film

The creation of active files by subject, name or number, using microfilm as the filing instrument, is now possible with Kard-a-Film. Kard-a-Film combines the space savings of microfilm and the

reference benefits of paper record filing while making it easily possible to check microfilmed records at points of usage. Plans for marketing include Sealed Kard-a-Film which requires mounting the film in die-cut cards by use of an acetate lamination that seals in and protects the film, and Insert Kard-a-Film, designed to permit slipping filmed images into a slot in the edge of the card, individually or in groups, as required. This permits the customer to make up his own record cards. Either method permits the addition of new active records as required or the removal of inactive ones.

Kard-a-Film is also usable with all known filing systems utilizing present



filing cabinets, indexing systems and folders when grouping Kard-a-Film under one subject is necessary. One 8 by 5 inch Kard-a-Film card will hold sixty-five 11 by 8½ inch microfilmed records. Both cards are available in sizes from 2½ by 3 inches to 14 by 11 inches. Indexing can be done on both the card and the film in this system. The card may be tabbed, labelled, coded or colored for swift finding. Records can be indexed by name, number, title, date or subject. Remington Rand Inc., Dept. MH, 315 Fourth Ave., New York 10. (Key No. 667)

## All-Purpose Cleaner

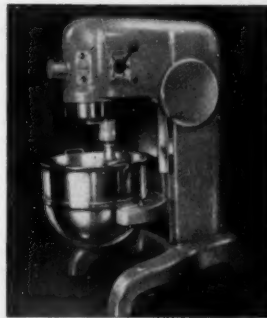
The new West All-Purpose Cleaner combines the advantages of an all vegetable oil soap with those of a synthetic detergent and an alkaline polyphosphate water softener. It produces very good foam and excellent detergency and is formulated for efficient action in hard

water as well as soft, either hot or cold, and with savings in time and labor. It is designed for practically any cleansing operation, including scrubbing, mopping and washing all types of floors, woodwork, painted walls, windows and other surfaces. It is economical in use, is prepared in relatively high dilutions, and when stronger concentrations are required for cleaning particularly dirty areas, it is said to be harmless to surfaces while doing its work effectively. West Disinfecting Co., Dept. MH, 42-16 West St., Long Island City 1, N. Y. (Key No. 668)

## Hobart Mixer

The new Hobart Model L-800 all-purpose mixer is the result of years of experience in building quality mixers. The new mixer has a capacity of 80 quarts and features a timed mixing control which automatically shuts off the machine in any speed after the time set has elapsed. If desired, the machine can be set on "hold" position so that the automatic timer is inoperative.

The body of the mixer is streamlined in design and easy to keep clean, finished in standard Hobart gray. It has four positive speeds which may be pre-selected or changed during operation. Hobart planetary action achieves precise, uniform mixing action for thorough blending,



mixing and aerating of all ingredients in the bowl. The Hobart Manufacturing Co., Dept. MH, Troy, Ohio. (Key No. 669)

(Continued on page 216)

## What's New ...

### Light and Sound Conditioning System



The new Curtis Light and Sound Conditioning System provides a comfortable quality of illumination based on three factors. These include the source, or fluorescent lamps operating at about half normal brightness; the shielding, accomplished by the size and positioning of the acoustical panels which conceal the lamps from normal viewing angles, and the surroundings, which contemplate light colors of room surfaces and furnishings. The packaged system consists of 96 inch fluorescent lamps with wiring, ballasts and lampholders in place, and 1 by 8 foot baffles consisting of panels of  $\frac{1}{2}$  inch acoustical tile set in metal frames which are hung vertically from the ceiling with the lighting fixtures. Both exposed surfaces of the acoustical material are perforated.

The system provides adequate quantity and high efficiency along with quality illumination throughout the entire room. It should be particularly effective in interns' and nurses' classrooms, clinics, out-patient departments, offices and similar areas of the hospital. Luminaire sections are factory wired so that all lamps on the window side of a room may be placed on one switch circuit and the remaining lamps in the room may be placed on another switch circuit or circuits. Thus installation may be made so that lamps on the window side of the room may be turned off during the brighter periods of the day.

The installation is designed so that the spacing and use of low-brightness lamps minimizes shadows and reflected glare while providing effective lighting. At the same time, operation is economical because of the reduced wattage consumption. The acoustical treatment compares favorably with results obtained with the more familiar mounting of acoustical sections horizontally on the ceiling. Hanging vertically, the panels collect little dust and require infrequent cleaning. Comprehensive studies of lighting values, noise reduction coefficients, reverberation time and other details are available and indicate the efficiency of the system. Curtis Lighting, Inc., Dept. MH, 6135 W. 65th St., Chicago 39. (Key No. 670)

### Plastic Band-Aid

Band-Aids, the ready-to-use protective dressings for small areas, are now available in plastic strips. They are thin and smooth and fit close to the skin. They stretch with the movement of the skin, are flesh-colored, to blend with skin tones and thus are hardly noticeable, and the plastic surface sheds dirt and grease. The strips are waterproof and do not become loose or soggy when wet, are non-curling and non-fraying. The new plastic Band-Aids are individually wrapped and are sterile, ready for use. Johnson & Johnson, Dept. MH, New Brunswick, N. J. (Key No. 671)

### Film Dryer

A new low cost x-ray film dryer is being introduced. It is compact, for bench mounting, and has a capacity of twelve 14 by 17 inch films. Wet films dry in 40 to 50 minutes in the new unit which has a removable stainless drip tray. A combination toggle switch permits adjustment for heat and blower



or for blower only. The door of the dryer is equipped with a magnetic device to hold it closed during operation. The dryer is finished inside and out in light green baked enamel. Westinghouse X-Ray Corp., Dept. MH, 2519 Wilkens Ave., Baltimore 3, Md. (Key No. 672)

### Cancer Tele-Therapy Unit

The high-energy radiation of radioactive cobalt is utilized in a manner similar to that of x-rays in the new GE Cobalt 60 Cancer Tele-Therapy Unit. The unit utilizes the rays from sufficient distance from the patient to permit treatment of sizeable areas, to treat deep or otherwise inaccessible cancers, and to reduce the need for "planting" cobalt 60 surgically in the tissues. The unit was originally conceived by the late Dr. Leonard Grimmett. The energy of the cobalt unit will be clinically equivalent to that of a 2,000,000 electron volt x-ray unit, an energy widely used in deep cancer therapy. The lower cost of the cobalt 60 unit will make possible its wider use in hospitals.

The source of the radiation in the new

unit is four "wafers" of cobalt, each 1 inch square and  $\frac{1}{4}$  inch thick. To make cobalt radioactive, cobalt 59 is bombarded with neutrons in a pile for six months to one year. An extra neutron lodges in the nucleus of some of the cobalt atoms, producing an unstable isotope, cobalt 60. It decomposes, giving off a beta particle (electron) and two gamma rays (x-radiation). A wafer loses half its strength in 5.3 years. Wafers are housed in Hevimet, a GE tungsten alloy which confines the emanation of radiation to a small opening. The first Cobalt 60 unit is being installed at the Oak Ridge Institute of Nuclear Studies, Oak Ridge, Tennessee, for testing and biological studies, until it is eventually moved for medical use and study to the M. D. Anderson Hospital, Houston, Texas. General Electric Co., X-Ray Dept., Dept. MH, 4855 Electric Ave., Milwaukee 14, Wis. (Key No. 673)

### McLellan Suction Unit

The McLellan Suction Unit is a small portable apparatus for administering mild, continuous suction at the bedside. It can be easily carried to the bedside and placed in operation in a few minutes. Automatic, continuous operation, maintaining a constant negative pressure, is available as long as desired. The unit weighs only 11 pounds and occupies but 6 by 12 inches of space. It is powered by a slow speed 20 watt induction motor with a capacity more than adequate for gastro-intestinal drainage. It is quiet in operation and the valve shuts off suction automatically when the collection bottle is full.

A pressure gauge indicates at all times the amount of negative pressure being used while a pressure lock prevents pressure control being moved accidentally. A "T" connection is provided with the third connection closed off. A clamp at the bottle permits shutting off the vacuum so that water or liquid medications may be administered to the patient with a syringe through the third



connection of the "T" back through the Levine tube to the stomach. Burdick Corp., Dept. MH, Milton, Wis. (Key No. 674)

(Continued on page 218)

*No need to tip toe...*

# Kentile Rubber Tile

gives hospitals quiet, restful floors  
of "cushioned beauty"

**K**ENTILE RUBBER TILE is so easy to keep spotlessly clean . . . smooth "Cushioned Beauty" tiles with precision tightness, resist dirt and stains, and insure "hospital sanitation" . . . maintenance costs are reduced to a minimum.

Due to its remarkable construction, Kentile Rubber Tile always looks polished, gleaming smooth . . .

Quick, tile-by-tile installation saves labor costs, too . . . Kentile Rubber Tile goes down so fast . . . can be walked on as soon as it's down. Beautiful, cheering colors can't wear off . . . they go all the way through each rugged tile.

So, for quiet floors that soften every footstep, every sound . . . for lasting beauty and cleanliness through years of wear . . . choose Kentile Rubber Tile every time! For extra custom-design beauty in special rooms choose ThemeTile decorative inserts, only available in Kentile Rubber Tile!

For further information contact your local Kentile flooring contractor, listed under FLOORING in the classified phone directory, or our office nearest you:



## KENTILE RUBBER TILE®

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KENTILE, INC., 58 Second Avenue, Brooklyn 15, New York • 350 Fifth Avenue, New York 1, N. Y. • 705 Architects Building, 17th and Sansom Streets, Philadelphia 3, Pennsylvania • 1211 NBC Building, Cleveland 14, Ohio • 225 Moore Street, S.E., Atlanta 2, Georgia • 2020 Walnut Street, Kansas City 8, Missouri • 1440 11th Street, Denver 4, Colorado • 4532 South Kolin Avenue, Chicago 32, Illinois • 1113 Vine Street, Houston 1, Texas • 4301 Santa Fe Avenue, Los Angeles 58, California • 93 Market St., Oakland 4, Calif. • 452 Statler Building, Boston 16, Mass.



## What's New . . .

### Heavy Duty Vacuum Cleaner



Model WD-23 is a new, quiet, wet-dry vacuum cleaner for institutional use. Powered by a 1 h.p. Universal type motor, moistureproof and rubber mounted, the unit picks up water, dirt and dust with a water lift of 63 inches. The 15 gallon tank of 18 gauge steel is reinforced for strength and both interior and exterior are porcelain lined to prevent rust and corrosion. The unit is readily mobile as it is mounted on four free-running, ball-bearing swivel type rubber casters.

A special dump valve on the tank provides for quick, easy draining, thus avoiding any possible injury to the operator. A newly developed positive action shut-off device warns the operator when the tank is filled to capacity. A protective, non-marking rubber bumper surrounds the entire base of the machine as a protection to walls and furniture. The new Clarke Model WD-23 is furnished complete with hose, wand, water pick-up squeegee tool and pick-up tool for carpets. Also available are tools for all special cleaning needs. Clarke Sanding Machine Co., Dept. MH, Muskegon, Mich. (Key No. 675)

### Germicidal Cleaner

A new liquid germicidal cleaner has been introduced that thoroughly cleanses while deodorizing and disinfecting the areas treated. It should be of particular interest for maintenance in the hospital and the three-way action eliminates the need for more than one product to do the complete maintenance job.

Known as Korex Germicidal Cleaner, the product is a unique compound combining soap, a synthetic detergent, a germicide, a wetting agent and penetrant with water softeners and emulsifiers. It is unaffected by water hardness, cuts through dirt, breaks it down and floats it away in one application. With a phenol coefficient of 2, its germicidal

properties are effective against many bacteria. It is highly concentrated and diluted up to 40 to 1 with water before using. It has been proved effective, through extensive testing, on all types of floors and on furniture, woodwork, walls, hard goods furnishings, leather and metal. It is said to be safe on any surface unharmed by water and not to irritate human skin. Huntington Laboratories, Inc., Dept. MH, Huntington, Ind. (Key No. 676)

### Dry Chemical Extinguisher

Very light weight and maneuverability are features of the new stainless steel 20 and 30 pound capacity dry chemical fire extinguishers. The maneuverability of the new models permits the operator to reach the seat of the fire without any lost motion. The extinguisher is operated by finger tip control which shoots a chemical heat insulating cloud up to 20 feet, snuffing out flames on contact, even at a long range. The chemical used in the new extinguisher produces 1100 times its volume in non-toxic, flame-killing gas. The new unit gives protection against class B and C fires and the company reports it is Underwriters' Laboratories approved. The Buffalo Fire Appliance Corp., Dept. MH, Dayton 1, Ohio (Key No. 677)

### Explosion-proof Germicidal Unit



Designed for use in operating rooms, the new Explosion-proof Germicidal Lamp Unit is said to eliminate the possibility of post operative infection caused by airborne contamination. It is also safe from causing any danger of explosion of anesthetic gases.

The unit is designed for wall or ceiling mounting to furnish direct or indirect irradiation. Two Hanovia hair pin shaped Safe-T-Aire lamps furnish the ultra violet energy. Hanovia Chemical & Mfg. Co., Dept. MH, 100 Chestnut St., Newark 5, N. J. (Key No. 678)

### Pressurized Roach Spray

A new type roach killing formula is being presented in the Holcomb Pressurized Roach Spray. It is effective in eliminating roaches by two methods: direct contact, which brings immediate death to the roach, and a colorless, odorless deposit which is effective in killing roaches for a period up to eight weeks.

The new product is pleasantly scented and will not stain or discolor fabrics or surfaces. The active ingredients are finely dispersed in the carrier and forced

into cracks and crevices. By pressing the release valve on the Aerosol Container, the surface is sprayed with the material until wet. The residue remains effective for weeks, thus making the product economical in use. J. I. Holcomb Mfg. Co., Dept. MH, 1601 Barth Ave., Indianapolis 7, Ind. (Key No. 679)

### Spectro-Heat Burners

Spectro-Heat is the name now being used to designate Garland front-fired all-hot top for all commercial ranges. The Spectro-Heat hot top has seven front-fired burners, each individually controlled, permitting 50 per cent gas consumption without restriction of the cooking area. Heating with graduated intensities is made possible by the front-firing, adding an element of flexibility of heat over a great area. The chef can get high heats at the front with receding heats toward the rear, or any other heat intensities on the same top at the same time from the same burners. Since each burner has its own control, heat can also be varied from side to side. The new Spectro-Heat hot top facilitates cooking and simplifies work.

The Spectro-Heat top is also available in stainless steel ranges and can be used in ranges designed for manufactured, natural or Liquefied Petroleum gases. Detroit-Michigan Stove Co., Dept. MH, 6950 E. Jefferson, Detroit 31, Mich. (Key No. 680)

### Rotary Snow Plow

The Jari Jr. Rotary Snow Plow is designed to do an hour's snow shoveling in ten minutes and to function efficiently in wet and slushy snow, dry or packed snow. It is a light, powerful, self-propelled rotary snow plow with a rotary rake which chews the snow for easy removal. The open front cuts a swath 16 inches wide and scoops the snow in for quick pick-up. An adjustable casting chute directs the snow stream out of the path. The two wheel drive has positive forward movement obtained by hard-



ened steel pinions engaging notches in rubber tires. Jari Products, Inc., Dept. MH, 2938 Pillsbury Ave., Minneapolis 8, Minn. (Key No. 681)

(Continued on page 220)

A PICTURE OF

Cleanliness



#### THE SPOTLESS

### GAS Kitchen

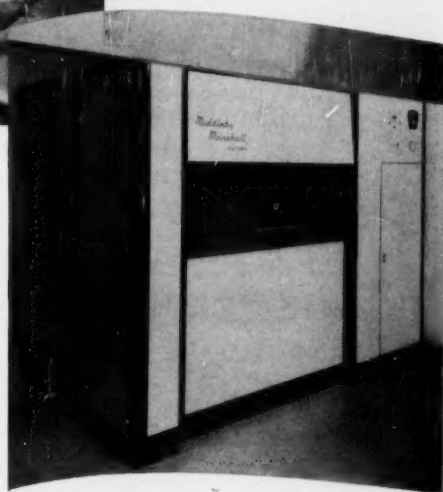
of St. Vincent's Hospital provides 2500 meals daily for patients and staff. The speed and economy of GAS for cooking and baking provide top efficiency in handling and preparation of food. Cleanliness of GAS is in keeping with St. Vincent's highest sanitary standards.

#### A PICTURE OF EFFICIENCY

### this GAS Fired Bake Oven

keeps the Hospital supplied with pastries, cookies and cakes. After the baker has completed the day's baking, the oven is used for meat roasting, to utilize the heat stored in the oven.

Here is real food preparation economy—with GAS.



### St. Vincent's Hospital

Toledo, Ohio, finds that Modern Gas Kitchen Equipment pays off—in speed, flexibility, economy and cleanliness. Remember that Blue Flame Gas Cooking and Baking can do the same for you. Get the details today, from your Gas Company Representative.

MORE AND MORE...

**THE TREND IS TO GAS**  
FOR COMMERCIAL COOKING

AMERICAN GAS ASSOCIATION • 420 LEXINGTON AVENUE, NEW YORK 17, N. Y.

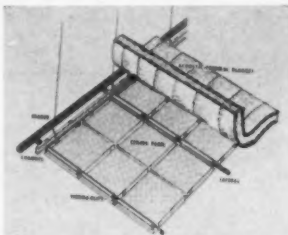
## What's New . . .

## Acoustical-Radiant Ceiling

Radiant heating is combined with acoustical correction in the new Burgess-Manning radiant ceiling. The ceiling brings radiant heating from above and distributes it evenly to all parts of the room. The entire aluminum ceiling radiates heat. Ceiling panels are easily snapped into place and removed for inspection or other services. Installation is easy and may be made in new or re-modeled construction. The perforated aluminum panels and heating units are attached to channels suspended from the ceiling by 3/16 inch pencil rods or their equivalent. Hot water flows through the two main "headers" connected by laterals spaced one or two feet apart which heat the entire ceiling. The ceiling may also be used to provide summer air conditioning with cold water circulating through the system and absorbing heat.

An acoustic-thermal blanket is installed wall to wall over the heating coil. This blanket absorbs a large percentage of the noise and also acts as a thermal insulator and vapor barrier. Water is heated by a conventional boiler and the ordinary room thermostat is usually sufficient to regulate the temperature. Installation may be handled by local contractors but materials, which are prefabricated and need no alteration, are provided by the manufacturer, including engineering

service. The ceiling is the invention of Gunnar Frenger, Oslo, Norway. Rights have been acquired by the local company which has further developed the



system. Burgess-Manning Co., Architectural Products Div., Dept. MH, 5970 Northwest Highway, Chicago 31. (Key No. 682)

### Glass Filler

For convenience in dining rooms, cafeterias, utility rooms, floor service rooms, floor kitchens and other areas, the new Meadowbrook fixture should be of interest. It has two self-closing faucets, each equipped with a stem-and-disc. Slight pressure against the disc causes full flow of water from the faucet.

and fills a 10 ounce tumbler in less than three seconds. The overall width of the fixture is 24 inches and it is 13 inches deep. The 8 inch high back protects the wall against splashing. The fixture is made of high-gloss vitreous china for easy cleaning and all fittings are of chromium-plated brass. **Kohler Co., Dept. MH, Kohler, Wis. (Key No. 683)**

## Floor Level Cleanout

The new Supremo "Perfect Seal" Floor Level Cleanout has been designed to permit quick and easy access to drainage lines located in heavy traffic areas. A plug which forms a gas and water tight seal in the Cleanout is so constructed as to assure access to drainage lines with ease, even after many years. The threads of the plug cannot "freeze" to the body, thereby eliminating the possibility of damage to the plug or to the cleanout body as the plug is being removed. Known as model Z-1325-10, the unit is so constructed that the housing is separate from the body, thus making it possible for the pipe to contract or expand, or the surfacing material encasing the housing to settle, without causing damage to the cleanout or pipe. J. A. Zum Mfg. Co., Dept. MH, Erie, Pa. (Key No. 684)

(Continued on page 222)

# TEMPERATURE *alone*

## is not enough to sterilize your surgical packs

Temperature is only ONE of the three essentials of sterilization. Pure steam, maintained at the correct temperature, for the correct time—as all needed to kill bacteria in your autoclave. Anything less is dangerous and uncertain.







# ATI STEAM-CLOX

*Check*  **STEAM**  **TIME**

## TEMPERATURE

### *The Three Essentials of Sterilization*

ASPETIC-THERMO INDICATOR CO.

**SEND FOR THIS COMPLETE STERILIZATION FILE... AT NO CHARGE OR OBLIGATION**

**Sterilization Service Bureau**  
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☐ Please send complete sterilization file.  
☐ Please have service representative call.  
☐ Please send \_\_\_\_\_ books of ATI Steam-Clos  
(number) \_\_\_\_\_

**@ \$6.25 per book of 250 indicators.**

**My name** \_\_\_\_\_  
**Title** \_\_\_\_\_  
**Hospital** \_\_\_\_\_

**Address** \_\_\_\_\_  
**City** \_\_\_\_\_ **State** \_\_\_\_\_

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*For a quarter century our campaigns have succeeded not only financially, but in the excellent public relations we have established for our clients.*

*Consultation without obligation  
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**NEW...ready-to-use**  
**antibiotic combination**

# Combiotic\*

(Penicillin and dihydroStreptomycin)

AQUEOUS SUSPENSION

provides in each disposable cartridge or 2 cc. dose from vial

Procaine penicillin G . . . . . 400,000 units

Dihydrostreptomycin (as the sulfate) . . . . . 0.5 Gm.

**Supplied:** Single injection B-D† disposable cartridge syringes; 10 cc. "drain-clear" vials containing 5 doses.

## clinically preferred...

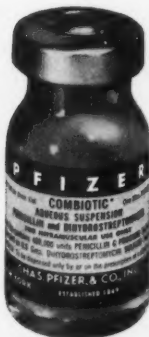
in the treatment of certain mixed infections of the urinary tract, acute gonococcal infections, in selected cases of sub-acute bacterial endocarditis, and in surgical prophylaxis

## because of these advantages...

- no mixing or reconstitution necessary
- microparticle suspension flows easily through 22-gauge needle
- drain-clear cartridge and vial means ability to withdraw full labeled volume
- buffered for stability; maintains full potency for one year under refrigeration

a new PFIZER antibiotic specialty recently added to the full line of PFIZER penicillin, streptomycin, polymyxin, bacitracin and Terramycin dosage forms to meet all requirements of every hospital service for convenient and effective antibiotic agents

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Antibiotic Division



CHAS. PFIZER & CO., INC., Brooklyn 6, N. Y.

## What's New ...

### Silex Coffee Warmer

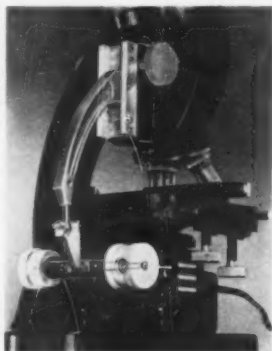
A new two-unit coffee warmer has been added to the Silex line. The new unit is compact and the enclosed elements are easy to keep clean. It is 14 inches long, 5 3/4 inches deep and 3 3/4 inches high, taking up a minimum of space. Each burner uses only 100 watts so that the WS-2 can be plugged into any ordinary electrical outlet. The Silex Co., Dept. MH, 88 Pliny St., Hartford 2, Conn. (Key No. 685)

### Laboratory Microscopes

A new line of laboratory microscopes features ball bearings and rollers throughout the focusing system. Called Dynoptic Labrosopes, the new instruments have a low position fine adjustment and a mechanical stage with low controls that enable the operator, after setting the coarse adjustment, to rest his hand on the table and manipulate the other controls in a relaxed position.

Effortless turning of the focusing knob is assured by a ball bearing on the horizontal shaft of the low position fine adjustment which also absorbs thrust. Two rollers on the lever transfer horizontal movement of the screw to vertical travel of the focusing slide. The slide is fitted with ball bearings assembled

in pressure plates. The nose-piece has ball bearings around its outer rim and a ball stop. Additional substage equipment includes a Variable Focus Condenser in a tubular mount which does not require a rack and pinion substage.



A substage illuminator is available which can be used integrally with the Labroscope in place of the mirror or separately. The new equipment is the result of several years of research. Bausch & Lomb Optical Co., Dept. MH, 635 St. Paul St., Rochester 2, N. Y. (Key No. 686)

### Patient's Call Signal

The patient's call signal on the all electric Ideal Underbed Oxygen Tent is conveniently located on the patient's side of the vertical column for easy operation within the canopy. However, the signal itself is now housed in a small box which can be placed in the corridor and is electrically connected with the apparatus. This call-box provides an audible buzzer as well as a flashing, visible signal. Thomas A. Edison, Inc., Medical Gas Div., Dept. MH, Stuyvesant Falls, N. Y. (Key No. 687)

### Small Utility Lamp

A new portable fluorescent lamp is now available which is very small but produces intense, cool illumination of up to 450 foot candles of light. It contains two 4-watt fluorescent tubes and all components within a 2 by 6 inch drawn shade. The jackknife support bracket contains three adjustable links, each three inches long. It may be removed from the cast base for permanent installation on a desk, table or machine. Swivel joints are provided at each joint as well as in the head and base to allow adjustment to any position. Stocker & Yale, Inc., Dept. MH, Marblehead, Mass. (Key No. 688)

(Continued on page 224)

simplify  
and save



Gennett Ice Cart  
Model XV  
Capacity 150 lbs.

You can have all the ice you need right at your fingertips—in the Gennett Ice Cart. Combine service with effortless, silent mobility and simplify ice handling. Fill at your ice machine and save on trips, save time. The heavily insulated, all Stainless Steel Gennett stores and saves unused ice.

The Gennett is sturdy; built to last for years. Pneumatic tires on the 12" wheels; easily drained, easy to clean. Send for catalog and prices.

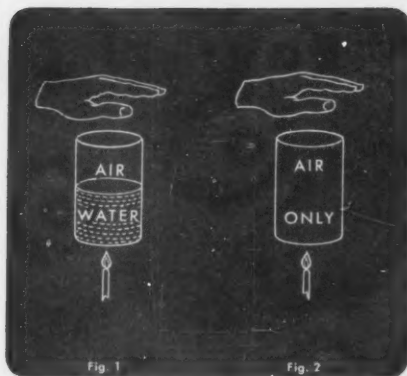
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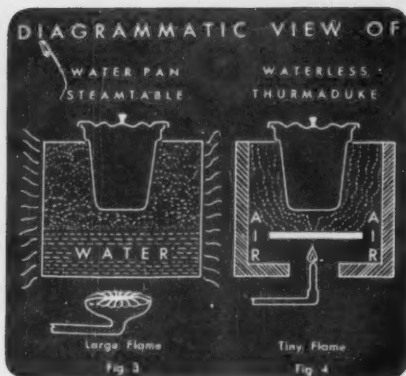
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HEADQUARTERS  
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EQUIPMENT, FURNISHINGS AND SUPPLIES

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2201 S. LA SALLE ST. Dept. 17 CHICAGO 16, ILL.





Place a can half filled with water over a small flame. Do the same with an empty can. Notice how much more quickly the empty can heats up.



It takes much more heat to warm water than air. That's why the burners in a waterpan steam table are much larger than the tiny jets in THURMADUKE.

*here's how you can prove*

## THURMADUKE *saves up to 70%*



See your THURMADUKE Dealer or write for Catalog MH-12

The simple experiment above shows why *waterless* THURMADUKE uses so little gas. Numerous case records from THURMADUKE owners are further proof of this fact.

The THURMADUKE waterless principle offers many other advantages, too: *fast* heat — because no time is wasted heating gallons of water. *Controlled* heat — in each section. This permits you to keep each food at exactly the proper temperature to insure peak flavor, appearance and minimum shrinkage.

Add to these outstanding features, the beauty of THURMADUKE design, the superior construction and insulation, and you'll want a THURMADUKE, yourself.

DUKE MANUFACTURING COMPANY • ST. LOUIS 6, MISSOURI

## What's New ...

### Redesigned Cantor Tube

The new improved Cantor Intestinal Decompression Tube is available in adult and child sizes. It has been redesigned with a sealed distal end, greatly simplifying the technic. It is only necessary to attach a disposable neoprene-natural rubber bag to the sealed end of the tube. The bag is pierced with a 21 gauge needle and the puncture creates a safety valve for accumulated gases in the bag during long periods of intubation. After intubation the bag is stripped off and discarded and the tube may be used again with a fresh bag after disinfection. Clay-Adams Co., Inc., Dept. MH, 141 E. 25th St., New York 10. (Key No. 689)

### Sterile Operating Lamp

The Sterile Operating Lamp, which projects a beam of cold parallel light rays, is now explosion proof and spark-proof and the manufacturer states that it complies with the requirements of the NFPA and the National Electric Code for hospital operating rooms. The sterilizable, interchangeable lucite light bars are used for projected light. They are maneuverable by the operating surgeon into the work area at any needed angle. The lamp standard may be draped with

a sterilizable cloth sleeve.

The lamp is available in two models. Model A mounts anywhere on any operating table rail. When not in use it fits into a carrying case of plywood, leatherette covered, with chromium



hardware. Model AP is a self-supporting portable floor model. The base of the lamp may be raised or lowered on the column. It is equipped with solid bronze sparkproof base and electrically conductive, locking type casters. Harold L. Feighner & Co., Dept. MH, 11814 Wilshire Drive, Detroit 5, Mich. (Key No. 690)

### Pressed Tableware

A new line of pressed tableware is being introduced with two new items; a 4½ ounce and a 3½ ounce sherbet dish. The new line will be known as Libbey "Durapress" glassware. It will be built to take rugged handling and have true brilliance and high eye appeal. The new pressed items are attractive in design, with smooth, rounded edges which lessen the possibility of chipping. Libbey Glass Co., Div. of Owens-Illinois Glass Co., Dept. MH, Toledo 1, Ohio. (Key No. 691)

### Lung Testing Equipment

The new Medart Wet Spirometer for precision testing of the lungs incorporates many new features. Of practical design, the new test uses a float chamber principle which requires no counter weights, to obtain unusually accurate balance. Scale readings remain constant until instantly reset with a finger-tip valve control. The scale is adjustable up to 400 cubic inch capacity. The Spirometer is constructed entirely of brass and aluminum and comes complete with hose and six glass mouthpieces. It is finished in gray enamel. Fred Medart Products, Inc., Dept. MH, 3535 DeKalb, St. Louis 18, Mo. (Key No. 692)

(Continued on page 226)

Institutions, Industrial Plants, Schools, Camps, Mills, Hotels, Railroads, Canneries, Caterers, Steamships, Large Government and Commercial Feeding Operations.

**THEY ALL DEPEND ON AERVOIDS TO MOVE HOT FOODS**



Only AerVoIDs Are All-Stainless Steel ... Vacuum Insulated.

The trend toward more and more centralization of food production on large feeding operations calls every day for more and more AerVoID Carriers to move hot foods and liquids.

AerVoIDs alone are all-stainless steel combined with health-approved vacuum insulation. AerVoIDs alone provide the highest SANITARY standards. AerVoIDs alone provide the durability to stand up under rough usage and spread their cost over a long period of service. AerVoIDs alone meet the requirements for handling of any quantity or any number of hot foods.

WRITE FOR FOLDER MH 6 "The Modern AerVoID Way"

**VACUUM CAN COMPANY**

19 South Hoyne Avenue

Chicago 12, Ill.

**AERVOID** Vacuum Insulated  
Hot Food, Soup and Coffee Carriers

## THE LATEST IN SPRING DESIGN..



The Hall All-Position spring adjusts to the important positions for medical and surgical treatments. Head and feet sections have a drop, from the horizontal, of 7 to 2 inches. Head and foot ends when furnished with the All-Positions Spring have lower cross rods and longer fillers or panels so when either spring end section is in its lowest position, the closed space keeps the bedding from sliding. This modern spring requires a minimum of effort to adjust and offers the patient maximum comfort and body support.

The precision-made Hall All-Position spring fits any Hall hospital bed. For detailed information, write.

**FRANK A. HALL & SONS**  
Since 1828

200 Madison Avenue, New York 16, N. Y.

Factories at 120 Baxter St., New York and Southfield, N. Y.

**HALL BEDS WEAR LONGEST—GIVE BEST SERVICE**



## Cure for a clinic's Flooring ailments...



A clinic, too, can have *its* physical troubles.

Floors, for example, can become worn out . . . or cracked. They can have anemic-looking colors. Suffer from shabbiness, drabness, etc.

But *fortunately*, for every flooring ailment, there's a good, fast cure: Tile-Text® Asphalt Tile.

*Fast?* Yes, indeed. It takes only a jiffy to install Tile-Text . . . without closing off areas, either. And its benefits are felt *immediately*.

Tile-Text appearance is so neat and attractive . . . its colors so clear and true . . . it spreads cheerfulness wherever it goes.

As for *wearing* qualities, Tile-Text has stamina to spare. It takes "all that the traffic will bear" from a

steady stream of patients, doctors, nurses, orderlies, wheelchairs, operating tables, etc.

Yes, after years and years of wear, Tile-Text still looks young and healthy.

Tile-Text is easy to keep clean, too! Just sweep daily. Mop periodically. Wax occasionally.

Ask your Tile-Text contractor to give you complete information and free estimates about Tile-Text flooring.

Then *you* be the doctor. Make *your* diagnosis. \*

(Bet you'll prescribe Tile-Text, too.)

THE TILE-TEXT DIVISION, *The Flintkote Company*,  
1234 McKinley St., Chicago Heights, Ill.

*The Flintkote Company of Canada, Ltd.*, 30th Street,  
Long Branch, Toronto, Canada.

REGISTERED TRADEMARK, THE FLINTKOTE COMPANY



# TILE-TEXT...The Quality Asphalt Tile

## What's New ...

### Diesel Electric Plant

A new 3000 watt Diesel Electric Plant, driven by an improved four-cycle single-cylinder Onan DSP Diesel engine is now available. The engine incorporates many new engineering features that have increased power output and operating efficiency with economy. The simplified design of the plant makes it possible for anyone to operate and service this new Model 3DSP-1E unit. Push-switch control for electric cranking, manual compression release and an electrically heated glow-plug for cold weather starting are provided. The unit is compact, easily installed, and generates 115-volt, 60-cycle, single-phase current. **D. W. Onan & Sons Inc., Dept. MH, University Ave. S.E. at 25th, Minneapolis 14, Minn. (Key No. 693)**

### Wet Colostomy Set

The Pierce Wet Colostomy Set, designed by Dr. Virginia Pierce, is designed for post-operative use by patients in whom one or both ureters have been transplanted into a sigmoid terminal colostomy. It can also be used for ileostomies. The set includes three bags which the patient, with the surgeon's help, adjusts for himself to maintain continuous comfort by means of progressive and accurate fit. This saves waiting

for bags to be made to the patient's specifications.

The appliance is leakproof through use of the new United Skin-Hesive, cre-



ated especially for the Pierce set. **United Surgical Supplies Co., Dept. MH, 160 E. 56th St., New York 22. (Key No. 694)**

### Anti-Slip Wax Veneer

To protect against slipping on floors finished with wax, Kerns Floor-Grip contains Ludox, a colloidal silica, which gives adhesion to the floor surface when pressure is applied. The product offers the usual advantages of self-polishing floor wax plus the anti-slip safety feature. Floor-Grip is so formulated that walking pressure produces a snubbing action that helps produce a non-slip surface, whether wet or dry. **Floor-Grip**

(Continued on page 228)

is applied like any self-polishing wax, requiring no buffing, but a high gloss may be obtained by buffing.

The new product spreads quickly and easily and produces a hard, flexible, smooth, soil-repellent surface. It is effective on rubber tile, asphalt tile, linoleum, terrazzo, marble and wood. Where needed, spot-waxing of worn areas may be done without evident signs of overlap. Floor-Grip is packed in 5 gallon pails and in 15, 30 and 55 gallon drums. **J. F. Kerns Co., Dept. MH, 350 W. Ontario St., Chicago 10. (Key No. 695)**

### Waterless Potato Peeler

The new Dickar Electric Waterless Potato Peeler is designed for use as a table model. No water is needed in peeling and waste is emptied into a pail or can so that plumbing is not needed. A unique blower system moves waste to a throat and down a chute.

The unit is ruggedly constructed of heavy cast aluminum. It is simple in construction and operation and requires no oiling. The peeling pot has a clear plastic window and functions to throw potatoes on the peeling disc all at one time. The unit can be self-cleaned with very little water. **Service Appliance Co., Dept. MH, 1775 Broadway, New York 19. (Key No. 696)**



**CATALYTIC  
PROCESS**

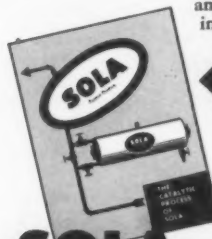
*Eliminates*

**SCALE**

**AND REDUCES RUST**

**in Boilers, Heaters & Water Systems**

SOLA is the modern Catalytic process that prevents the formation of scale and gradually reduces old scale and corrosion in hot and cold water systems, creating crystal clear water without any change to the chemical structure. Less expensive than any other treatment. Simple to install and operate.



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**SOLA CATALYTIC CO.**  
520 BROWDER ST., DALLAS, TEXAS



*Time Tested-Quality Proven*  
**HODGMAN SHEETINGS**  
ARE STANDARD AMONG LEADING HOSPITALS

Meet all requirements of American Hospital Association. Ask your supply house or send for sample swatches of regular and lightweights.

**HODGMAN RUBBER CO.**

FRAMINGHAM, MASS.

Offices in New York, Chicago and San Francisco



# Cortone<sup>®</sup>

## for topical use in eye diseases

CORTONE has proved remarkably effective in the treatment of many inflammatory eye diseases. *Topical* administration is indicated principally in disorders of the anterior segment—the cornea and anterior uvea.

### Three products for Individualized Dosage:

#### OPHTHALMIC SUSPENSION OF CORTONE Acetate

**0.5%—5 cc. vials:** For more superficial and less serious indicated conditions and for continuing treatment in severe eye conditions after preliminary therapy with the 2.5% strength has achieved the desired degree of improvement.

**2.5%—5 cc. vials:** For treatment of the more severe indications and for initial therapy of any indicated condition that potentially might lead to permanent ocular damage.

#### OPHTHALMIC OINTMENT OF CORTONE Acetate

**1.5%—3.5 Gm. tubes:** For use in conjunction with either of the ophthalmic suspension preparations, or alone, depending on the condition present; particularly useful for bedtime application.

Administered topically in recommended dosage, CORTONE is

**Nonirritating — Safe — Economical**

For diseases of the deeper structures of the eye, it is recommended that adequate systemic dosage with the *Oral Tablets* or the *Parenteral Suspension* of CORTONE accompany or precede topical application.

Literature on Request

**Cortone<sup>®</sup>**  
ACETATE  
(CORTISONE Acetate Merck)



**MERCK & CO., INC.**  
Manufacturing Chemists  
RAHWAY, NEW JERSEY  
In Canada: MERCK & CO. Limited—Montreal

CORTONE is the registered  
trade-mark of Merck & Co., Inc.  
for its brand of cortisone.



## What's New . . .

### Nursery Pads

Nursery pads of superfine Fiberglas covered with a tough, light weight plastic film are designed to be used through the infant's stay in the hospital. They can be placed in the delivery room with a sheet, the infant placed on the pad and as a unit taken to the nursery and put in the bassinet. The pad can be removed from the bassinet with the infant at bath time and can be wiped off with a disinfectant and returned to the bassinet, thus eliminating the laundering of cotton pads. The heat retaining quality of Saniglastic Nursery Pads is an advantage with the new born infant but lessens with use so that the infant is gradually adjusted to a normal bed. The pads are soft and comfortable, impervious to mineral oils and acids and do not stain from blood or grease. Saniglastic Co., Dept. MH, 805 Madison Ave., South Milwaukee, Wis. (Key No. 697)

### Electric Snow Remover

Snow is tossed up to 20 feet to either side with the new Sensation Electric Snow-Blo. Direction of the throw of snow is determined by a reverse rotation switch on the handle which is located for quick operation. The machine is powered by a 1/2 h.p. capacitor motor

and the chassis of the Electric Snow-Blo is constructed entirely of steel with an open bottom friction-fed sidewalk scoop. A grounding drag chain is used to eliminate electrical shocks. The two-way discharge feature makes the unit especially adaptable in clearing walks and drives bordered by a wall or fence. The



machine weighs 63 pounds and has an adjustable handle to fit the operator's height, plastic handle grips and 100 feet of No. 14 plastic cord. Sensation Mower, Inc., Dept. MH, Ralston, Neb. (Key No 698)

### Blood Transfusion Set

A new blood transfusion set is now available which is designed to give a double filtration: a coarse filtration in the bottle and a fine filtration in the stat set. With this system it is possible

to avoid the failure of the blood filter by becoming clogged so that the blood will not flow.

The Continental plastic filter is of woven construction with alternate double rows of plastic thread so that the surface is not smooth, thus helping to prevent the filtered particles from clinging to the filter. As the bottle was also designed for the administration of blood under pressure, the Continental sealed air vent tube has been incorporated. This air vent tube, used with a sterile air filter, carries the air under pressure over the blood and thus avoids the possibility of the air being drawn out through the recipient needle with the blood. The single needle of the recipient stat set is forced through the cap into the center of the bottle filter and this filter has been so designed that it will filter out all particles that might clog the recipient needle. Three filter porosities are available: the coarse filter in the bottle with openings corresponding to approximately a 20 mesh screen; the medium filter which may be ordered in the recipient sets corresponding to approximately a 48 mesh screen, and the fine filter which is standard in the recipient sets and corresponds approximately to a 110 mesh screen. The Continental Pharmaceutical Co., Dept. MH, 4821 W. 130th St., Cleveland 11, Ohio. (Key No. 699)

(Continued on page 230)



Ask for Catalog #950.

(#1624 T TWIN TANK UNIT illustrated below.)



### GEERPRES WRINGER, INC.

Manufacturers of High Grade Mopping Equipment  
P. O. Box 658 . . . . . Muskegon, Mich.

**Saves Time  
Saves Work  
Doubles Mop Life  
No Splashing  
Saves Cleaning Compounds  
30% Lighter**

Acknowledged to be the most rapid acting wringer on the market, the famous downward-pressure GEERPRES flushes the water out of the mop uniformly and without splash. Elimination of pulling and twisting of mop gives longer mop life. All GEERPRES wringers are built for long service, with utmost strength and minimum weight. Fully guaranteed.

Also: Tangleproof mop sticks, mop buckets on casters, mopping trucks.

**EVEREST & JENNINGS**  
*pioneers in wheel chairs for every handicap*

**HOLLYWOOD**  
Toilet  
COMMODO  
Model #5

Metal Commode Chairs were pioneered by Everest & Jennings, recognized leaders in the Wheel Chair field. All models can be equipped with bed pan and slides. Footboards are available for all models. 5" casters and legs are interchangeable. The Combination Commode with four extra legs is convertible into three models—the Combination Commode, the Toilet Commode and the Bedside Commode.

Write for information and complete catalog.

DISTRIBUTED BY  
**EVEREST & JENNINGS**  
761 N. Highland Ave., Los Angeles 38, Calif.

**BEDSIDE COMMODO**

**COMBINATION COMMODO**

## Look to **VOLLRATH** first for the Complete Line of Quality Institutional Ware

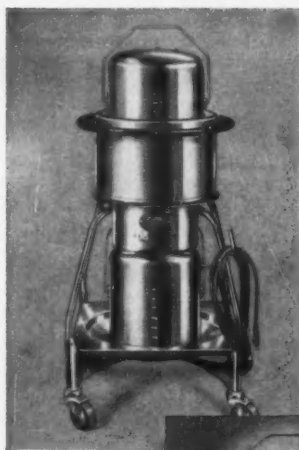


### GRADUATED STAINLESS STEEL BEAKERS

Look at these five measures—a complete set designed to serve every need. All the functional qualities you've ever wanted are built into every one . . .

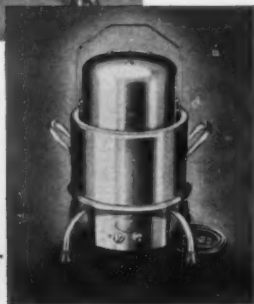
- Smooth, tapered sides—easy to handle.
- A large lip—easy to pour.
- Permanent, die-embossed graduations—ever-legible, easy reading in ounces and cubic centimeters.
- Stainless Steel—unbreakable, easily sterilized.
- Easily nested and conveniently stored.

This complete set of beakers is now available through your Vollrath jobber. Order today.



### PAK-HEATERS for HOT-PAK THERAPY

These stainless steel Hot-Pack Heaters are exclusive specialties in the complete line of Vollrath porcelain enameled and stainless steel wares. Floor Model No. 9101 for hospital use; Portable Model No. 9102 for use in home, clinic and doctor's office. Easily operated on AC current, equipped with automatic cut-off switch—both models produce packs of uniform temperature and moisture content—quickly, steadily, safely!



The  
**Vollrath Co.**  
SHEBOYGAN, WIS.

NEW YORK • CHICAGO • LOS ANGELES

## What's New . . .

### Pharmaceuticals

#### Terramycin Optic

Terramycin is now available in form for the treatment of external ear infections. The new dosage form consists of a vial containing 25 mg. of crystalline terramycin hydrochloride and a dropper bottle containing 5 cc. of a mixture of 95 per cent propylene glycol and 5 per cent benzocaine. The two mix to make a clear solution which remains stable under refrigeration for 48 hours without loss of potency. Terramycin optic solution combines antibiotic action to destroy bacteria, the benzocaine to ease pain and discomfort and the propylene glycol to soften waxy deposits and relieve congestion. **Chas. Pfizer & Co., Inc., Dept. MH, 630 Flushing Ave., Brooklyn 6, N. Y. (Key No. 700)**

#### Sharcillin Aqueous Suspension

Sharcillin Aqueous Suspension is a sterile, free-flowing product prepared from crystalline procaine penicillin G monohydrate with dispersing agents added, for the treatment of infections in which penicillin is indicated. The product is ready for immediate use, is designed for intramuscular injection and contains 300,000 units of crystalline procaine penicillin G in aqueous suspen-

sion in each cubic centimeter. It is supplied in 1 cc. disposable cartridge syringes. **Sharp & Dohme, Inc., Dept. MH, 640 N. Broad St., Philadelphia 30, Pa. (Key No. 701)**

#### Cortogen Acetate Ophthalmic

Cortogen Acetate Ophthalmic Suspension has been developed for controlling the inflammatory phase of ophthalmic infections. It blocks normal tissue response to infections, allergens and trauma but causative organisms are not impaired and infections must be treated by concomitant specific therapy. Each cc. contains 5.0 mg. cortisone acetate, suspended in a buffered isotonic low surface tension aqueous vehicle. **Schering Corp., Dept. MH, Bloomfield, N.J. (Key No. 702)**

#### Orgalac (R)

Orgalac (R) is a new nutrient formula containing calcium, phosphorus, iron and iodine (organically combined) in two readily assimilated forms: powder and tablets. Orgalac powder and tablets are prepared as dietary supplements during growth, pregnancy and lactation and in old age. The tablets are supplied in bottles of 100 and the powder in 250 gram jars. **Henry K. Wampole & Co., Inc., Dept. MH, 440 Fairmount Ave., Philadelphia 23, Pa. (Key No. 703)**

(Continued on page 232)

### Fergon Plus

Fergon Plus is a new hematinic preparation designed for therapy in most types of anemia. It is supplied in the form of soft gelatin capsules and is a special preparation of ferrous gluconate and vitamin B<sub>12</sub>, folic acid, gastric mucosa, ascorbic acid and liver fraction 2. Besides iron deficiency anemias, therapeutic indications for the new product are anemias responding to oral vitamin B<sub>12</sub> or folic acid therapy. It may also be administered as a prophylactic, constituting a dietary supplement. It is supplied in bottles of 100. **Winthrop-Stearns Inc., Dept. MH, 1450 Broadway, New York 18. (Key No. 704)**

### Estan

White's Estan combines Dienestrol with Methyltestosterone in a ratio designed to produce the maximum benefits of sex hormone therapy without undesirable side effects. It is designed for treatment in menopause, dysmenorrhea, male climacteric, post-partum suppression of lactation, osteoporosis and malnutrition. It is supplied in scored tablets for oral administration, in bottles of 30 and 100. **White Laboratories, Inc., Dept. MH, 113 N. 13th St., Newark 7, N. J. (Key No. 705)**

## The Time-Tested Material For Better CO<sub>2</sub> Absorption



Furnished in 3 standard mesh sizes (Tyler or U.S.S.), high or low moisture content, packed in drums, jars or pails. Both regular and indicator types.

5-gal. pails of SODASORB now equipped with new pop-up pouring spouts for greater convenience.

SODASORB, WILSON Reg. U. S. Pat. Off.

Genuine WILSON SODA LIME — SODASORB — has been the standard CO<sub>2</sub> absorption material used by leading hospitals for over 30 years.

SODASORB is made with a special granular structure that gives it unusually high powers of absorption. Each granule has a unique, coral-like shape that gives the greatest possible area of absorbing surface, and that causes granules to tumble naturally into an alignment which permits free intergranular circulation of the gases, with no flat surfaces that could stack or block. For best results, specify SODASORB. Order from your hospital supply house, or write for free technical data now.



Cambridge 40, Mass.  
Montreal 22, Canada

## Buy Quality For Economy

The Longer-lasting linens you get at BAKER are expressly woven for service. They pay off in lower linen costs.

**H.W. BAKER LINEN CO.**

EST. 1882

Oldest and largest Organization of its kind in the U.S.

315-317 Church St., New York 13, N.Y.  
and 12 other cities


# Brand new!

## a 6-page guide to better patient bookkeeping

This folder shows you a practical and  
economical way to mechanize your accounting  
and slash your clerical costs

Four main features make this tested method especially helpful to hospitals at a time when budgets are strained and clerical help is hard to find.

1. Patient's statement and ledger are *always* up-to-date and accurate. All items are fully described with minimum writing. All records are neat and easy to read. Delays are eliminated at cashier's window. No errors or misunderstandings with patients.
2. You get a complete departmental revenue analysis as a by-product of posting the patient accounts. At the end of each day, without further effort, totals by department are ready to show where your money is coming from and why.
3. There is no difficulty in balancing books at the end of the month because all records are kept automatically in agreement and all entries are proved correct *at the time they are made*. Most errors are discovered instantly, rather than requiring a long search at the end of the month.
4. No special operators need be hired. Your present bookkeeping staff can easily learn to use the single-keyboard Remington Rand accounting machine. And the same machine can also handle your payroll and accounts payable with similar speed and accuracy.



Prompt Patient Statements with Analysis  
and Journal Distribution, too  
...all in the same single operation  
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the Remington Rand accounting machine

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call **Remington Rand**  
or visit our Business Equipment Center in your city

## What's New ...

### Methods Manuals

The new Squibb Antibacterial Chart has been designed as an aid for hospitals and is available from E. R. Squibb & Sons, 745 Fifth Ave., New York 22. It provides latest information on the relative effectiveness of the various antibacterial agents and represents a consensus of leading authorities in the antimicrobial field. It is 8½ by 11 inches in size and may be hung on the wall, posted on the bulletin board or placed under the glass on a desk. One side shows the relative effectiveness of the various agents against the causative organisms and the other side against the actual disease. (Key No. 706)

A new Picker Technical Publication, "Heart Size Measurements in Children," is available from Picker X-Ray Corp., 25 S. Broadway, White Plains, N. Y. Prepared by Dr. Esquerre Gomez, the new publication extends the roentgenographic method of heart size prediction to include children. It complements two earlier Picker technical texts, "Heart Size Measurements" and "Roentgenology of the Heart." (Key No. 707)

The Sixth Edition of the dishwashing manual prepared by Economics Laboratory, Inc., 914 Guardian Bldg., St. Paul 1, Minn., is now available. Entitled

"Dishwashing Dividends, the Way to Better Dishwashing," the comprehensive manual covers every phase of dish handling with each step covered by both text and illustration. The data included also covers maintenance of the dish pantry, care of dishwashing machines, and gives information on various types of dishwashing machines. Also available from Economics Laboratory, Inc., is a motion picture, "Dishwashing Dividends," presenting the same information visually, in color, and audibly. (Key No. 708)

"Don't Make an Ash of Yourself by Smoking in Bed" is the warning message on a red and black card, with cartoon type illustration, which is offered to hospitals without charge, in any quantity desired, by the Publicity Dept., The Travelers Insurance Co., Hartford 15, Conn. The card is small, 4 by 5 inches in size, and designed to stand on the bedside table. The artwork is done by cartoonist Bill Holman and the light, humorous presentation of the admonition should be effective. (Key No. 709)

A new pocket-size 8 page booklet on "The Facts About Prefinished Wallpanels" is being offered by the Prefinished Wallpanel Council, Keith Bldg., Cleveland 15, Ohio. The booklet is designed to answer briefly a number of

questions most frequently asked about this permanent, smooth-surfaced covering for walls and ceilings. (Key No. 710)

### Product Literature

• A new Hospital Apparel Catalog has been issued by Angelica Uniform Co., 1427 Olive St., St. Louis 3, Mo. Illustrating many new ideas in garments designed to improve the comfort of both patients and hospital personnel, the catalog features more than 100 men's and women's uniforms and over 40 accessories for all types of hospital personnel. (Key No. 711)

• A new 28 page illustrated catalog has been released with full detailed information on the Mitchell line of commercial fluorescent lighting units. Catalog No. 433 issued by Mitchell Mfg. Co., 2525 N. Clybourn Ave., Chicago 14, covers all commercial lighting needs with a wide choice of proper lighting for schools, colleges, hospitals and other institutions. Featured are high efficiency Slimline models; open-type, glass shielded and louver shielded Toffers; strip lighting units; streamlined shielded luminaires; pace setting spotlights, and many others. Also included in the catalog is complete information on accessory equipment for the luminaires. (Key No. 712)

(Continued on page 234)

## Send for this 'Helpful Bulletin



Arguments Efficiency  
Contamination Losses  
Economy



### Think Of All The Reasons Why You Should Mark Everything with

You wouldn't knowingly wear someone else's uniform or clothing; you wouldn't knowingly use linen from "contagious" in "maternity". But how can you know unless things are marked—marked with owner's name or the places they belong? Danger of contamination is only one reason why Cash's Woven Names are used so extensively in the medical and nursing world. Marking with Cash's also reduces losses, ownership arguments, and increases both efficiency and economy. The name of hospital or personal owner, ward or department woven into a Cash's Name Tape protects your belongings permanently. Cash's Names stand boiling, won't run or fade. Easy to attach with thread or Cash's NO-SO Boilproof Cement (25¢ a tube).



Personal Name Prices	
3 Doz. \$2.25	9 Doz. \$3.25
6 Doz. \$2.75	12 Doz. \$3.75

Ask your Dept. Store or write us your requirements.



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# Mechanized Handling

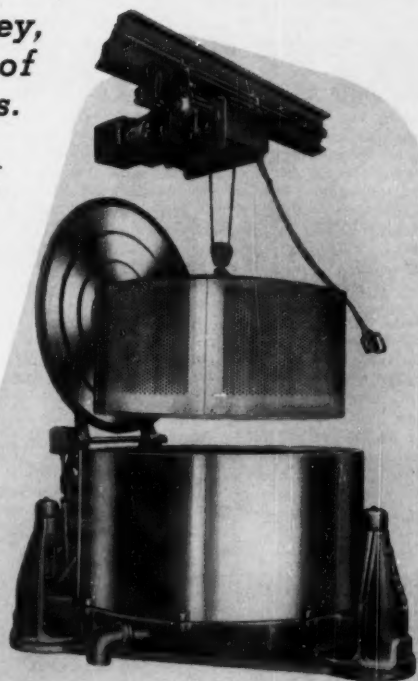
*saves you Manpower, Money,  
Minutes on Extraction of  
loads totalling in the tons.*

More and more—laundry operators are finding it's "penny wise, pound foolish" to handle daily tonnage manually at extractors. Modern mechanical equipment speeds production and cuts cost by processing loads on a bulk basis. Avoids delays and bottlenecks—avoids high, non-productive labor charges. Now investigate how you can increase profits on every pound of work with Hoffman "mechanized handling" Extractors.

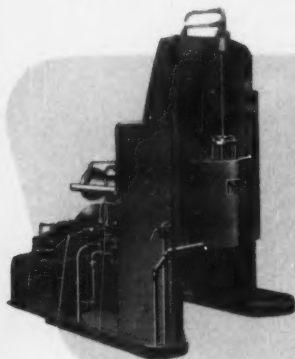
## HOFFMAN

UNLOADING EXTRACTORS

in 50, 54 and 60-Inch Diameters



OR...



*the fast-cycle*  
**HYDRAULIC EXTRACTOR**  
*for 2,500 Pounds Per Hour*

With unloading extractor, above, two basket halves of wet work are lifted by electric hoist—deposited directly into extractor. Then, extracted load is raised, rolled via overhead monorail, and dumped for tumbling or flatwork finishing.

Hydraulic Extractor provides 5-minute cycle for loading, extracting and unloading. 200-pounds per run. Quiet—vibration free—simple, single-lever control.

INSTITUTIONAL ... DIVISION



# Hoffman

U. S. HOFFMAN MACHINERY CORP. 105 FOURTH AVENUE, NEW YORK 3, N. Y.

## What's New ...

• The new **Pavilion line of patient room furniture** recently introduced is illustrated and described in a three color folder. The new folder is available from any of the three distributors of this attractive and practical line of furniture: W. & J. Sloane, 575 Fifth Ave., New York 17, Mandel Brothers, 1 N. State St., Chicago 2, and Barker Bros., 733 S. Flower St., Los Angeles 17, Calif. (Key No. 713)

• The new **Holophane "Datalog"** is a 64 page catalog of pertinent information regarding all Holophane products. It contains 90 product illustrations and many cross-sectional drawings and candlepower distribution curves. Special emphasis is given to the description, performance, application and installation as well as the dimensional data of these lighting units designed and engineered for specific purposes. The new Holophane Light and Vision Institute is also described. The "Datalog" is available from the Holophane Company, Inc., 342 Madison Ave., New York 17. (Key No. 714)

• "How You Can Reduce Your Maintenance Painting Cost" is the title of a booklet issued by Enterprise Paint Mfg. Co., 2841 S. Ashland Ave., Chicago 8. The booklet tells the story of Staize-Clene, the paint made with Syn-

con which prevents dirt and grime from penetrating into the pores of the paint film. Information on maintenance problems and on the use of Staize-Clene in hospitals and other buildings is included. (Key No. 715)

• The qualities and performance of **Joanna Vinylized Wall Fabric** are discussed in an 8 page illustrated brochure recently released by Joanna Western Mills Co., 22nd and Jefferson Sts., Chicago 16. The booklet presents a step-by-step story of the construction, application, wearing qualities and recommended uses of this plastic-on-cloth material developed to cut decorating costs for institutions since it is resistant to scuffing, scraping and bruising, stains and smears, and can be washed with plain soap and water or any ordinary cleaning solution. A card of actual samples is included. (Key No. 716)

• Complete descriptions and prices of Mertex glassware, Surgeons' brand scissors and forceps, funnels, syringes, cover glasses, hemacytometers, hemometers and other supplies for the hospital, laboratory and physician are given in the new comprehensive 132 page catalog issued by Mercer Glass Works, Inc., 725 Broadway, New York 3. All products are illustrated and the book is spirally bound to lie flat when open. (Key No. 717)

• The many new design and construction features in the extensive line of **Rectangular Surgical Supply and Bulk Sterilizers** manufactured by the American Sterilizer Co., Erie, Pa., are described in the new Catalog C-105R-29 recently released by that company. The 16 page catalog is illustrated with photographs and diagrammatic drawings and discusses all welded construction which eliminates all stay bolts and rivets; nickel clad chamber shell for corrosion resistance, and the Cyclomatic Control which permits one point automatic control of the sterilizing cycle. (Key No. 718)

• A discussion of Ciba's hospital sales policy, the scientific exhibits available to hospitals, publications and films of interest to hospital personnel and a hospital price list are included in the attractive booklet, "Your Hospital and Ciba," available from Ciba Pharmaceutical Products, Inc., Summit, N. J. (Key No. 719)

• Catalog L, released by Meierjohan-Wengler, 1102 W. 9th St., Cincinnati 3, Ohio, contains full information on ornamental lighting fixtures and lanterns. Hundreds of reproductions of ornamental lighting fixtures in bronze, wrought iron and aluminum are illustrated and full descriptive information is included. (Key No. 720)

(Continued on page 236)

*American*  
**Folding Chairs**

**NEW  
IMPROVED  
DESIGN!**



### BEST FOR EVERY FOLDING CHAIR PURPOSE!

- **DURABLE**—strong steel frame, reinforced
- **SAFE**—no tipping, pinching, snagging hazards
- **COMFORTABLE**—extra-wide, extra-deep seats and backs
- **CONVENIENT**—fold quietly, quickly, compactly
- **RUBBER SHOES**—long-life, replaceable
- **SEAT STYLES**—formed plywood with durable lacquer finish; or vinyl-plastic upholstered

OVER EIGHT MILLION IN USE!

WRITE FOR  
DESCRIPTORS  
AND PRICES

**American Seating Company**

Grand Rapids 2, Michigan

Branch Offices and Distributors in Principal Cities

THE  
**AMERICAN  
APPRAISAL  
COMPANY**



Valuation of  
**Tangible and Intangible  
Properties for  
Insurance Accounting  
Finance Tax and  
Legal Requirements**

**CLEANED IN A FLASH**

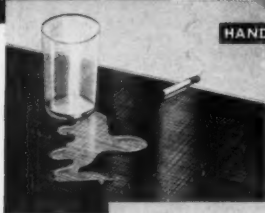
—any mess is  
wiped off in  
seconds.

**NEVER DENTED OR CRACKED**

—takes toughest  
abuse with a  
smile.

**RESISTS STAINING**

—even with al-  
cohol, bleaches,  
chlorides, dilute  
acids, boiling oil  
—even iodine!

**HANDSOME A LIFETIME**

—can't be burned  
by cigarettes or  
damaged by  
carelessness. (The  
Truwoods are real  
wood veneers  
Micarta-protected  
to make beautiful  
furniture.)

**A MAGICAL COLOR RANGE**

—from brilliant  
primary tones to  
smart and soothing  
pastels . . . in  
solids or wonder-  
ful patterns.

Discover  
this  
miracle  
plastic  
surface  
for ----

bedroom furniture, medicine tables, kitchens,  
laboratories, cafeterias, floor service centers—  
*everywhere in a hospital*

**IMPORTANT**

Only high pressure plastic laminates provide the maximum  
in wear and durability. Micarta is a high pressure laminate.



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UNITED STATES PLYWOOD CORPORATION  
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# Westinghouse **MICARTA®**

*is the  
miracle  
surface  
in  
hospitals*

**SEND FOR A FREE TEST SAMPLE**

Give Micarta your own third degree.  
See for yourself how specially  
wonderful Micarta is for hospitals.

UNITED STATES PLYWOOD CORPORATION  
55 West 44th Street, New York 18, N.Y.

Please send Micarta data and Test Sample.

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M.H. 12-61

## What's New . . .

• Several new recipe cards are now available from the Quantity Foods Recipe Department, Continental Coffee Co., 375 W. Ontario St., Chicago 90. They include chop suey, Boston cream pie, pineapple nut chiffon pie and a new idea for tomato consomme. They were prepared by Constance Conover, and are part of a complete assortment of cost-saving, quick recipes for easy-to-prepare soups, salads, entrees and desserts which are available from the company. (Key No. 721)

• **Pyromen**, a sterile, nonprotein and nonanaphylactogenic bacterial component for parental use in allergy, dermatology and ophthalmology, is discussed in a folder recently made available by Travenol Laboratories, Inc., Morton Grove, Ill. (Key No. 722)

• **"The Therapeutic Use of Cortone"** is the title of a 52 page booklet issued by Merck & Co., Inc., Rahway, N. J. This comprehensive discussion of Cortone includes chapters on treatment with Cortone of various conditions, with illustrations, and information on physiologic considerations, specificity of chemical structure and research and development. (Key No. 723)

• A complete new Catalog No. LP-31 of **"Laboratory Glassware"** has been issued by Corning Glass Works, Corning, N. Y. The 190 page book gives detailed descriptive information and prices on the full line of laboratory glassware available from this company and has a special section on Vycor brand laboratory glassware and its properties. (Key No. 724)

• Single tank deionizers of mixed-bed, monoflow design are described in **Bulletin 512** recently released by Elgin Softener Corp., Elgin, Ill. Entitled **"Elgin Ultra Deionizer,"** the six page bulletin gives technical and engineering data in addition to descriptive information on the deionizer and the results obtained by its use. (Key No. 725)

• A four page technical folder on **"Penetrating Protective Paints"** has been issued by the Wilbur & Williams Co., 130 Lincoln St., Boston 35, Mass. It is designed as a quick reference index for determining the most suitable coatings for rust prevention, chemical corrosion and dampness. (Key No. 726)

• A complete catalog of **Saunders Books for the Nursing Profession, 1951-52**, is now available from W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa. (Key No. 727)

**THIS COUPON** is provided for your convenience in requesting additional information.

- ☐ 666 Gas-Heated Ironer
- ☐ 667 Kerd-a-Film
- ☐ 668 West All-Purpose Cleaner
- ☐ 669 All-Purpose Mixer
- ☐ 670 Light and Sound Conditioning System
- ☐ 671 Plastic Band-Aid
- ☐ 672 Film Dryer
- ☐ 673 Cancer Tele-Therapy Unit
- ☐ 674 McClellan Suction Unit
- ☐ 675 Heavy-Duty Vacuum Cleaner
- ☐ 676 Korex Germicidal Cleaner
- ☐ 677 Dry Chemical Extinguisher
- ☐ 678 Explosion-proof Germicidal Unit
- ☐ 679 Pressurized Roach Spray
- ☐ 680 Spectro-Heat Burners
- ☐ 681 Rotary Snow Flow
- ☐ 682 Acoustical-Radiant Ceiling
- ☐ 683 Meadowbrook Glass Filler
- ☐ 684 Floor Level Cleanout
- ☐ 685 Silex Coffee Warmer
- ☐ 686 Dynoptic Laboscopes
- ☐ 687 Patient's Call Signal
- ☐ 688 Small Utility Lamp
- ☐ 689 Redesigned Cantor Tube
- ☐ 690 Sterile Operating Lamp
- ☐ 691 "Durapress" Tableware
- ☐ 692 Medert Wet Spirometer
- ☐ 693 Diesel Electric Plant
- ☐ 694 Pierce Wet Colostomy Set
- ☐ 695 Anti-Slip Wax Veneer
- ☐ 696 Waterless Potato Peeler
- ☐ 697 Nursery Pads

- ☐ 698 Electric Snow Remover
- ☐ 699 Blood Transfusion Set
- ☐ 700 Terramycin Optic
- ☐ 701 Sharcillin Aqueous Suspension
- ☐ 702 Cortogen Acetate Ophthalmic
- ☐ 703 Orgalac (R)
- ☐ 704 Fergon Plus
- ☐ 705 Estan
- ☐ 706 Antibacterial Chart
- ☐ 707 "Heart Size Measurements"
- ☐ 708 "Dishwashing Dividends"
- ☐ 709 "Don't Make An Ash of Yourself"
- ☐ 710 "Prefinished Wallpanels"
- ☐ 711 Hospital Apparel Catalog
- ☐ 712 Catalog No. 433
- ☐ 713 Pavilion Furniture
- ☐ 714 "Datelog"
- ☐ 715 "Reduce Painting Cost"
- ☐ 716 Joanna Vinylized Wall Fabrics
- ☐ 717 Catalog
- ☐ 718 "Bulk Sterilizers" Catalog
- ☐ 719 "Your Hospital and Ciba"
- ☐ 720 Catalog L
- ☐ 721 Quantity Recipe Cards
- ☐ 722 Pyromen
- ☐ 723 "Therapeutic Use of Cortone"
- ☐ 724 "Laboratory Glassware"
- ☐ 725 "Elgin Ultra Deionizer"
- ☐ 726 "Penetrating Protective Paints"
- ☐ 727 Nursing Books Catalog
- ☐ 728 Book
- ☐ 729 Books
- ☐ 730 Books

I should also like to have information on the following products

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 HOSPITAL \_\_\_\_\_  
 STREET \_\_\_\_\_  
 CITY \_\_\_\_\_ ZONE \_\_\_\_\_ STATE \_\_\_\_\_

MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc.  
 919 N. Michigan Ave., Chicago 11, Ill.

## Book Announcements

JeHarned, "Medical Terminology Made Easy," 275 pp., \$5. Physicians' Record Co., Dept. MH, 161 W. Harrison St., Chicago 5. (Key No. 728)

Flory, "Antibiotics," 40 pp., \$1.50. Hep-ler, "Manual of Clinical Laboratory Methods," 4th ed., 395 pp., \$8.50. Lippman, "Urine and the Urinary Sediment: A Practical Manual and Atlas," 128 pp., \$7.50. Marsh, "Outline of Fundamental Pharmacology," 220 pp., \$6. Charles C. Thomas, Publisher, Dept. MH, Springfield, Ill. (Key No. 729)

Barber, "Physiology and Pharmacology for Pharmaceutical Students," 3rd ed., 632 pp., \$6.50. Bolton, "Aids to Pharmaceutical Calculations," 103 pp., \$2. Harris, "Mode of Action of Anesthetics," 716 pp., \$8. Powell, "Orthopedic Nursing," 412 pp., \$5.50. The Williams & Wilkins Co., Mt. Royal & Guilford Aves., Baltimore 2, Md. (Key No. 730)

## Suppliers' News

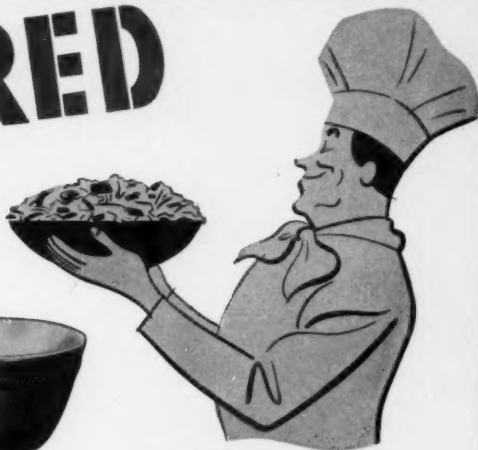
Bauer & Black, Division of the Kendall Co., manufacturer of hospital supplies, announces removal of its general offices from 2500 S. Dearborn St., Chicago, to 309 W. Jackson Blvd., Chicago 6.

Josam Mfg. Co., manufacturer of sanitary plumbing specialties, announces removal of its offices from 358 Josam Bldg., Cleveland 13, Ohio, to Michigan City, Ind.

Troy Laundry Machinery Division, American Machine & Metals, Inc., East Moline, Ill., announces that sales and service facilities are being continued at their San Francisco, California offices at 1201 Folsom St., in addition to its new offices in Los Angeles.

# PREFERRED

## for SALADS



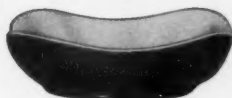
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1091 to 1098



281



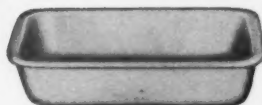
1210-1211



243 to 247



1102-1103



1122W



1120 to 1124

The preparation, serving, and storage of salads is an assured success when Hall China is used. Made of heavy china by an exclusive process . . . all Hall salad dishes are crazeproof, absorption-proof, and stainproof. Ordinary cleaning makes them as fresh and bright as new.

*Write on company letterhead for Catalog 48, which lists almost 1,000 different Hall China items and contains a color chart of the 26 beautiful underglaze colors that are available.*

**THE HALL CHINA COMPANY • EAST LIVERPOOL, OHIO**

*The World's Largest Manufacturer of Fireproof Cooking China*



*Spouts and bodies of Hall China teapot—cast separately—are assembled by hand.*



1200

Hall China salad dishes are available in sizes ranging from individual to banquet service.





*There's No Substitute for Experience!*



*... that's why GUMPERT Delivers*

### **Quality with Economy to Your Table**

**Have you tried GUMPERT'S  
SPAGHETTI SAUCE SUPREME**

More body—finest, freshest ingredients make this a more luscious and satisfying sauce. Contains plenty of fresh prime beef, real mushrooms, rich ripe tomato and vegetable goodness. All ready to heat and serve. Your sauce cost for a 12 ounce portion of spaghetti is less than 6 cents.

It takes experience to develop food specialties so outstanding that over 40,000 companies prefer them.

And it takes "know-how"—plus the finest ingredients and processing—to guarantee that these superior products deliver *not only quality but real economy.*

Figure the **TRUE COST**—the portion cost—not the invoiced price—and you'll find GUMPERT products the *thriftiest* food buy for your institution.

Want us to prove it? Ask your GUMPERT representative.

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